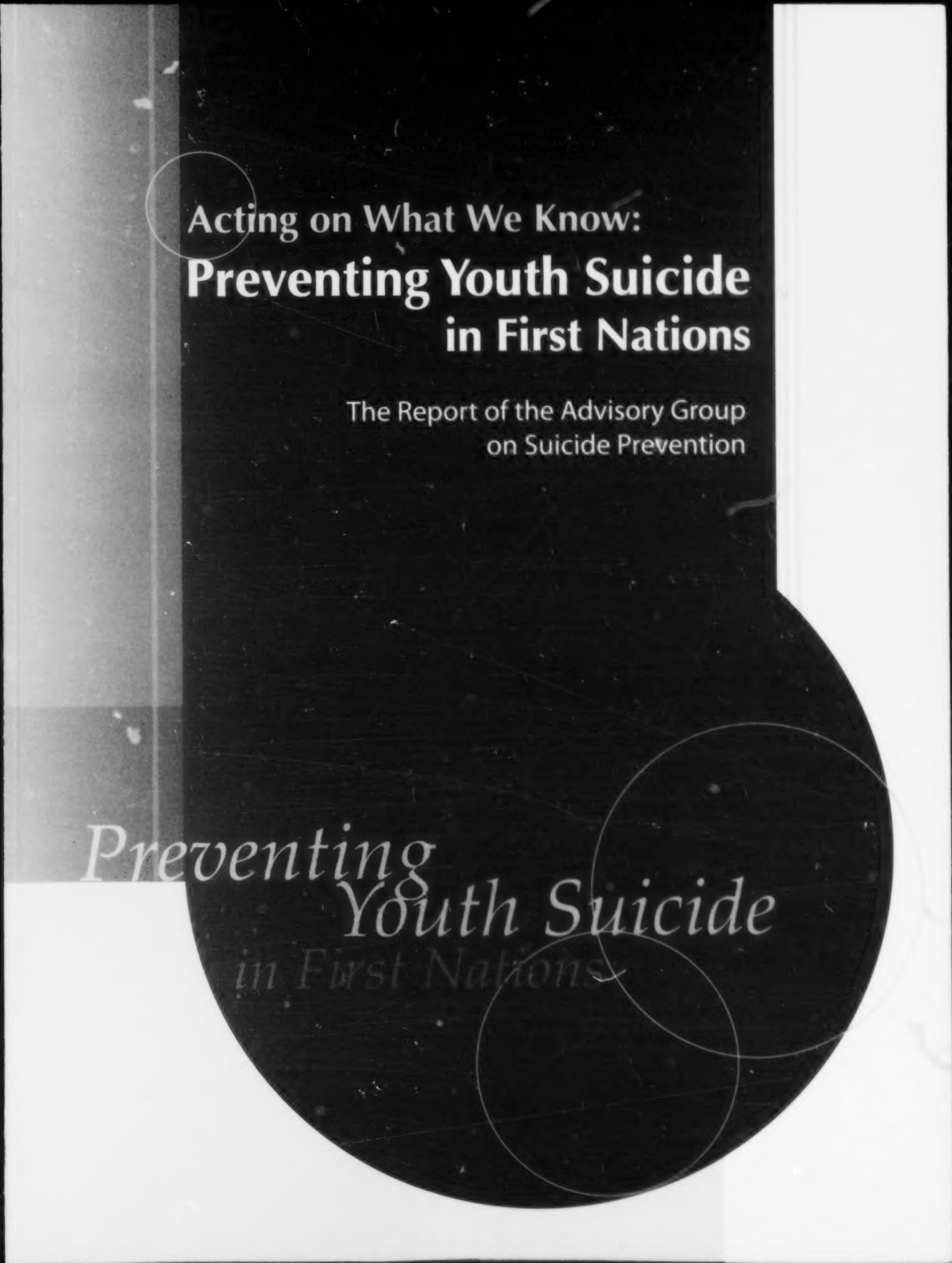

Acting on What We Know:
Preventing Youth Suicide in First Nations

The Report of the Advisory Group on Suicide Prevention

Preventing Youth Suicide in First Nations

Acting on What We Know:

Preventing Youth Suicide in First Nations

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Executive Summary

Suicide among First Nations youth has been occurring at an alarming rate in recent years. Statistics show an Aboriginal suicide rate two to three times higher than the non-Aboriginal rate for Canada, and within the youth age group the Aboriginal suicide rate is estimated to be five to six times higher than that of non-Aboriginal youth .

In July, 2001 a Suicide Prevention Advisory Group was jointly appointed by National Chief Matthew Coon Come of the Assembly of First Nations and former Minister of Health Allan Rock. The purpose of this Advisory Group was to review the existing research and formulate a series of practical, doable recommendations to help stem the tide of youth suicides occurring in First Nations communities across Canada.

The Advisory Group met between July 2001 and June 2002 to collaborate on this task. Through discussion, literature review and preparation of background papers, key issues were identified and recommendations generated. This report provides an examination of these issues, from basic suicide data to specific factors affecting First Nations, and based on this, presents recommendations for action.

The recommendations listed below fall into four main themes: (1) increasing knowledge about what works in suicide prevention; (2) developing more effective and integrated health care services at national, regional and local levels; (3) supporting community-driven approaches; and (4) creating strategies for building youth identity, resilience and culture.

No single approach is likely to be effective on its own. To reduce the risk of suicide, it is essential to make multi-level changes to systems that support youth, families and communities in crisis.

This report sets out a concrete series of steps, some of which can be immediately initiated by government and Aboriginal organizations. It is hoped that through these recommendations a collaborative and proactive response to First Nations youth suicide prevention will emerge.

SUMMARY OF RECOMMENDATIONS FOR PREVENTING YOUTH SUICIDE IN FIRST NATIONS POPULATIONS

INCREASING WHAT WE KNOW ABOUT SUICIDE PREVENTION IN FIRST NATIONS POPULATIONS

IT IS RECOMMENDED THAT

In the short term:

1 Health Canada, the Institute for Aboriginal Peoples' Health (IAPH, of the Canadian Institutes of Health Research) and other national and regional organizations place a high priority on research related to First Nations suicide, find and earmark new funding for this research, and issue a special call for proposals.

2 Health Canada, the Assembly of First Nations (AFN), and other agencies, ensure that any future suicide prevention programs contain an independent, systematic evaluation component.

3 Pilot studies and demonstration projects have clear objectives and a plan for the next stage of development that can be used to guide subsequent program development.

4 The IAPH set up a national coordinating group for research into mental health, psychiatric disorders, and suicide prevention to:

a) encourage surveys and evaluations to be conducted in a manner that allows pooling of data and comparisons across communities and regions;

b) collaborate with local groups in conducting well-designed studies on epidemiology and outcome evaluation; and

c) encourage the sharing of data and dissemination of findings as a means of providing public education and increasing community awareness (see appendix H, figure I).

In the long term:

5 Health Canada link with the IAPH, AFN, National Aboriginal Health Organization (NAHO), the Native Mental Health Association of Canada (NMHAC), the Aboriginal Nurses Association of Canada (ANAC), and other organizations to convene a national conference on suicide prevention which would advance the discussion on suicide, transfer skill sets, offer workshops on how to collect data, and conduct evaluations and educate communities on the benefits of open sharing of epidemiological and evaluative data.

6 The IAPH and NAHO create a national clearinghouse and website for information on best practice models and culturally sensitive methods of health research and evaluation in Aboriginal communities and populations. This should be linked to similar groups and sites working in U S, Australia, New Zealand and other countries to address mental health issues with Aboriginal peoples.

DEVELOPING EFFECTIVE AND INTEGRATED HOLISTIC HEALTH CARE AT NATIONAL, REGIONAL, AND LOCAL LEVELS

IT IS RECOMMENDED THAT

In the short term:

7 The mandate of the Non-Insured Health Benefits (NIHB) program, as outlined in the "Interim Program Directive for Mental Health Services" (March 1994) be reviewed and evaluated by the First Nations and Inuit Health Branch (Health

Canada) and AFN to determine how well it is meeting the needs of communities in crisis.

8 NIHB funding for mental health services be increased and funding for traditional practitioners be established. Further, that Regional Offices of FNIHB encourage more latitude and a broader interpretation of the NIHB Program Directive for Mental Health Services to allow for greater access to services on-reserve in all regions.

9 A demonstration project of the "Community Crisis Assessment Guideline" (see draft guideline, Appendix F) be undertaken to involve communities in a process that will identify preconditions for suicide and determine their level of risk for suicides.

10 Health Canada earmark funding for the development of educational materials that are both culturally sensitive and relevant (e.g. videos, posters, pamphlets). These materials would address issues such as help-seeking for depression or crises as well as promotion of positive mental health and wellness.

In the medium term:

11 Health Canada initiate and support the creation of a comprehensive national First Nations mental health strategy (including mandate, policies, and programs) that integrates approaches to suicides, psychiatric disorders, and other critical mental, physical, emotional, and spiritual problems in First Nations communities.

12 Current funding allocation methods (e.g. proposal-driven or per capita) be altered so that funding for mental health services in First Nations communities will be based on verified need as determined by a standardized assessment process. A program review, based on intended client and community outcomes, will form the basis for decision-making regarding future funding.

13 Psychotropic medication utilization patterns be reviewed and evaluated by FNIHB in collaboration with AFN and a clinical consultant, in relation to current expenditures. This evaluation can determine whether antidepressants and other medications are being used appropriately and whether some portion of the NIHB budget should be redirected to non-pharmacological interventions.

14 Mental health, holistic health, and social services workers be trained in case management, case conferencing, and other models that support integrated client services and collaborative interdisciplinary teamwork. In addition, these workers be further educated in techniques of suicide prevention, recognizing signs of depression, doing suicide risk assessment, and using community outreach approaches. This training could be supported by Health Canada, in collaboration with the AFN.

15 Designated professionals, including physicians, working in First Nations communities, be remunerated on a per diem basis (vs. fee-for-service) to encourage increased clinical supervision, multidisciplinary case conferencing, case management, and collaborative teamwork approaches.

16 Health Canada design and implement a national crisis consultation service to identify communities at high risk for suicides. For example, a community profile system (referred to in #9 above) can be developed nationally to assist communities to assess their psychological and social status, and their use of all national and provincial mental health-related funding and other services (e.g. BFI, BHC, NIHB, NNADAP, Aboriginal Healing Foundation, CFS etc.).

17 When communities are identified as being in crisis through this community assessment system, efforts be made to optimize health resources required, and available and accessible in and to that community. This assessment should be framed and described in positive, constructive terms for that community. Those communities at high risk for suicides should be offered professional mental health and cultural/traditional health services on a proactive basis before full-blown crises develop.

18 That Health Canada fund the creation and management of a national resource bank of mental health practitioners, including traditional healers, with substantial experience in First Nations crisis intervention, suicide prevention, and clinical practice and/or research. This group would meet on a regular basis to review progress in the area of crisis intervention, suicide prevention and postvention, to advise FNIHB and AFN, and to develop a collegial support network that would be available to community workers.

In the long term:

19 The national resource bank develop and implement a plan to support community workers through ongoing consultation, networking and follow-up using available technologies (i.e. on-site visits by invitation, internet/website, telepsychiatry, multimedia materials etc.). Such a plan would include a training/apprenticeship program. There would be a reciprocal flow of communication between the resource bank and the community workers that would provide updated information for the community profiles.

SUPPORTING COMMUNITY-DRIVEN APPROACHES

IT IS RECOMMENDED THAT

In the short term:

20 Health Canada make available to communities guidelines and links to resources (resource people, printed materials, networking with other communities or professionals) for developing a community-based postvention program (following guidelines based on the U.S. Centers for Disease Control) which can provide a basis for organizing a community response and plan for suicide prevention. This could include community healing and wellness circles.

In the medium term:

21 Health Canada, in partnership with First Nations, establish demonstration projects, using a formal community development methodology, to engage communities for the purpose of developing interventions that utilize a community's existing abilities, resources, and strengths to assist youth at risk, and that facilitators skilled in these approaches be used to guide the process.
If no one from the community is qualified, an outside facilitator should be engaged to introduce and mediate the process and prepare and equip local persons to carry on subsequent processes. Facilitators should have knowledge of First Nations history, cultures, communities, and tensions between effects of past oppressive forces and conditions necessary for self-determination. They should go through an orientation in each community with which they work.

22 Health Canada develop and make available a pool of facilitators knowledgeable in First Nations cultures and skilled in formal community development theory, techniques, and processes (see Appendix G), who have undergone an orientation by the community in which they will work. These facilitators can promote/implement the community engagement process and prepare and equip community members to sustain the engagement process.

23 Health Canada provide participating communities with funds to cover the costs of the community engagement process. The parameters for setting up pilot projects should give special consideration to the ideas of the youth and take into account community and regional differences across the country.

24 A national committee with representation from Health Canada and the AFN be created to develop criteria to be used to identify communities for involvement in the projects. That regional offices of Health Canada would implement the criteria in partnership with First Nations. When applied, the criteria should identify a range of communities with varying characteristics such as: remoteness and isolation; status of transferred health care; and level of risk for suicides.

25 The demonstration projects be supported by an administrative infrastructure that facilitates collaboration between federal and provincial governments (see Appendix H for details).
The administrative infrastructure should be integrated with structures to support the clinical and research initiatives outlined in Part One of this report. For example, the National Committee could develop and disseminate an information package on suicide prevention "best practices", and coordinate funders to support program ideas that emerge from the community development processes.

26 Each community have a coordinating committee to take responsibility for sustaining the community engagement process and ensuring specific initiatives are developed, implemented, and evaluated. Membership of the coordinating committee should consist of a cross-section of stakeholder groups: local elders, youth, cultural/traditional practitioners, health care workers, educators, social service workers, and representatives of the provincial government and Health Canada.

SUPPORTING YOUTH IDENTITY, RESILIENCE, AND CULTURE

IT IS RECOMMENDED THAT

In the short term:

27 The Youth Council at AFN, along with Health Canada, and the AFN Health Secretariat, convene a Roundtable to reflect on the recommendations in this report, respond to the ones that are most meaningful to the youth and recommend the best mechanism(s) for implementing them.

28 Health Canada and AFN establish a networking committee with a mandate to promote the roles and responsibilities of youth as peer counsellors, natural healers, and role models for one another. This should be done in conjunction with a media program to promote positive images of First Nations youth in a multimedia campaign.

29 Health Canada and AFN seek funds through available initiatives to determine best practice models for supporting parenting and family wellness in First Nations communities.

30 Health Canada and AFN work with IAPH and NAHO to support the development of projects aimed at enhancing youth's resilience, identity and culture.

Section 1

Acting on What We Know: Preventing Youth Suicide in First Nations

Introduction

In 1969, Harold Cardinal[1] reminded Canadians that the younger generation of First Nations had become a majority group with intense expectations and less patience for change. Today, First Nations youth are indeed making their presence known through their sheer numbers and much publicized lives and deaths. Restless spirits plague many of them and much has been written about their hunger for culture, identity and a future.

There is an unprecedented level of concern about First Nations youth suicide at the present time. Much of this concern has been driven by a series of dramatic events in places like Pikangikum and Sheshatshiu and the media and political debates that have taken place about these types of incidents. Because the coverage of these events knows no borders, the frustrated hopes of First Nations communities have become the purview of the world, not just of Canada. In general First Nations youth are portrayed as confused, thrown-away children with wasted lives and of real cost to society. Most important, this very public outcry has helped to stir the conscience of the communities and spur all levels of government to action. At the same time, recognition has grown that the issue of youth suicide has been too simplified, reduced and narrowed for lasting solutions to take hold.

Background: Suicide Prevention Advisory Group

In 2001, the National Chief of the Assembly of First Nations, Matthew Coon Come, and former Minister of Health, Allan Rock, appointed a panel of eight Aboriginal and non-Aboriginal researchers and health practitioners to make recommendations regarding the prevention of suicide among First Nations youth. The members of the Suicide Prevention Advisory Group were selected by the First Nations and Inuit Health Branch (FNIHB) of Health Canada and the Assembly of First Nations for their knowledge and experience in the areas of suicide prevention, health promotion and First Nations community development. The profiles of Advisory Group members are outlined in Appendix A.

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[1] Harold Cardinal. The Unjust Society. Republished in 1999. Douglas and McIntyre.

National Chief Coon Come and Minister Rock commissioned the Advisory Group to develop specific, viable strategies for short- and long- term action to address this issue, based on reviews of previous studies, current literature and assessment of service delivery gaps.

Methodology

The panel developed a detailed Terms of Reference (Appendix B), which stressed the need to produce strategies that would assist at-risk communities to develop their own responses to suicide. The main task for the Advisory Group was to review previous studies and recommendations pertaining to First Nations youth suicide and suggest concrete and achievable short- and long-term strategies for prevention.

Over a period of several months, panel members met to clarify their task, identify the major issues to be addressed and collaborate on reviews and discussions regarding these issues. Their efforts culminated in the attached findings and recommendations. Appendix C contains a complete listing of the documents reviewed.

The timeframes for this review precluded the direct input of First Nations youth through consultations. The panel noted that the views, opinions and recommendations of First Nations communities had already been expressed many times in the past and were contained in the literature to be reviewed (such as the Royal Commission on Aboriginal Peoples special report on suicide, "Choosing Life[2] ", the Nishnawbe-Aski Nation Forum on Youth Suicide[3] , and others).

Therefore, based on practical considerations, a decision was made to review the feedback previously given by First Nations youth and ensure their voice is reflected in the recommendations emanating from this report. It was also decided that a focus group of First Nations youth, parents and leadership should be convened at the end of the work to provide feedback on the Advisory Group report and recommendations (see Recommendation 27 in the Executive Summary).

In the process of review and discussion, four central concerns or themes emerged related to First Nations youth suicide: (1) the need for an evidence-based approach; (2) the need for effective and integrated health care; (3) the importance of community driven approaches; and (4) an emphasis on strengthening youth identity, resilience and culture. These themes are addressed in Section 3, parts 1 through 4 of this report. After much discussion, the Advisory Group reached consensus on a total of 31 recommendations that can be implemented within the short-term (up to six months), medium-term (within a year) and the long-term (one year and beyond), to address four main areas of concern related to First Nations youth suicide.

Description of This Report

This report picks up the dialogue on First Nations youth suicide by sounding out the depths of the problem from the various perspectives of the field of research in examining the role of government programs, community responses and individual choices.

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[2] Royal Commission on Aboriginal Peoples [RCAP], 1995, Choosing Life: Special Report on Suicide Among Aboriginal People, Ottawa, Ontario.

[3] Nishnawbe-Aski Nation Youth Forum on Suicide, 1995 – Horizons of Hope: An Empowering Journey, Final Report. Thunder Bay, Ontario.

The Advisory Group has attempted to look at First Nations youth suicide through many different lenses, applying its best thinking in considering what concrete solutions will be most helpful to First Nations communities. However, it is important to note that this report does not directly address the overwhelming needs of First Nations across Canada in terms of poverty, unemployment, overcrowding and inadequate housing. The chronic socio-economic conditions which continue to plague First Nations have been documented elsewhere and are beyond the scope of this report, thus are only briefly mentioned here. Much more work will be necessary, both to identify the extent to which lack of basic needs may impact on First Nation youths' suicidal behaviours, and to commit resources to dealing with the issue.

Some of the issues faced by First Nations youth on-reserve parallel their urban-based counterparts, however, in this report the discussion is limited to First Nations populations on reserves or in remote rural communities.

The opening section, Introduction to the Issue, summarizes some key suicide data. Findings from previous studies are highlighted to set the context within which First Nations youth suicide occurs. Clearly, the distress of many First Nations youth reflects broader family, community and historical issues.

The report then presents four main theme areas identified for action. Part I entitled What We Know: Putting Forward an Evidence-Based Approach, addresses the need for further research and information-gathering to address gaps in knowledge. Part 2, Toward Effective and Integrated Holistic Health Care at National and Regional Levels, highlights the lack of a national mandate for mental health services and coordinated funding mechanisms. Part 3, The Importance of Community-Driven Approaches, addresses the need for community ownership of the issue and control of developmental processes for responding to and preventing First Nations youth suicide. Part 4, Strengthening Youth Identity, Resilience and Culture, speaks to the need to support First Nations youth in making healthy choices as they cope with the challenges in their lives.

The conclusion outlines guiding principles and standards for implementing the recommendations contained in this report. Attached to this report are appendices presenting examples of recommended suicide prevention programs, a suggested administrative structure for the national, regional and local coordination of demonstration projects, and a draft tool to help First Nations communities assess the risk of youth suicide (for communities' further adaptation, development and internal use). Additional detailed information is also provided on federally funded programs, and community development approaches.

Given the timeframe and mandate of the Advisory Group, this report has certain limitations and it is important at the outset for the reader to be clear on what this report is and is not about:

- The approach is not about imposing foreign ideas on First Nations communities; however, it is informed by lessons learned from other sources including seminal American studies; as well as Aboriginal-specific sources and strategies.

- The emphasis is on evidence-based decision-making; this is at the core of this report making it necessarily technical in nature.

- The diversity of First Nations communities is not fully considered here; rather suicide is treated as the subject, which draws all to the table, and common issues are set out.

- There is an emphasis on rural (reserve) communities in this report despite the migration trends of First Nations between their reserve communities and towns and cities. We lack adequate information on the situation of urban First Nations populations. This report does not make direct reference to the integration of services in specific provinces or territories.

- The focus here is on influencing policy in suicide prevention; this report does not focus on healing movements and everyday forms of health and healing in communities. Traditional approaches are not central themes, but the report recognizes the important role that spirituality plays in health development efforts in communities.

- Choice is important in suicide prevention; therefore there is no one position taken on the best holistic approach that communities can take.

- Solutions lie in the communities, so a valid approach to suicide prevention must be comprehensive, touching all facets of the life of First Nations individuals, families and communities or it will not work. This means that suicide prevention will not be effective unless communities and government are working side by side in prevention efforts.

- Clearly, this analysis needs to be deepened at the community level; in this way it can be termed a living document. For instance, community leaders, including Chiefs and Councils, medicine men and women and elders are key resource people and gatekeepers for health and health care in First Nations communities, but this report stops short of exploring such community characteristics.

Section 2

Introduction to the Issue

Introduction

A review of the available literature shows that First Nations youth suicide is occurring at an alarming rate across Canada. Despite this, it should be possible to reduce suicide by making multi-level changes to the systems that youth, families and communities look to for support when they are in crisis. Many First Nations youth experience isolation, poverty, lack of basic amenities and family relationships which do not nourish and support them. Furthermore, colonization, marginalization and rapid cultural change have left them in the wake of foreign values and beliefs and deep conflicts about who they are. Therefore, a broad perspective is critical when looking at the problem of suicide and proposing tangible ideas for action.

Key Suicide Data

First Nations Youth Suicide Rates are High

Suicide occurs roughly five to six times more often among First Nations youth than non-Aboriginal youth in Canada. [4] The most recent edition of The Health of Canada's Children (Canadian Institute of Child Health [5]) compared First Nations and Canadian suicide rates from 1989-1993 for ages 0-14 and 15-24 years. The rate of First Nations youth suicide is extremely high (Figure 1). Among First Nations men between the ages of 15-24 years it was 126 per 100,000, compared to 24 per 100,000 for Canadian men of the same age group. Young women from First Nations registered a rate of 35 per 100,000 versus only 5 per 100,000 for Canadian women.

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[4] RCAP, Choosing Life, op cit.

[5] Canadian Institute of Child Health (2000), Ottawa, Ontario.

Studies at a regional level also highlight the serious problem of suicide among First Nations youth. Figures 2 and 3 illustrate the consistently high suicide rates for British Columbia (B.C.) Native youth. For the age group 15-24 years over a five-year period (1987-1992), B.C. First Nations youth had 108.4 suicides per 100,000 persons, while during the same period; non-Natives had 24.0 suicides per 100,000. Thus, B.C. First Nations youth have a suicide rate 4.5 times greater than non-Native youth.

Figure 1: Suicide Death Rates by Age Group
First Nations and Canadian Populations, 1989-1993

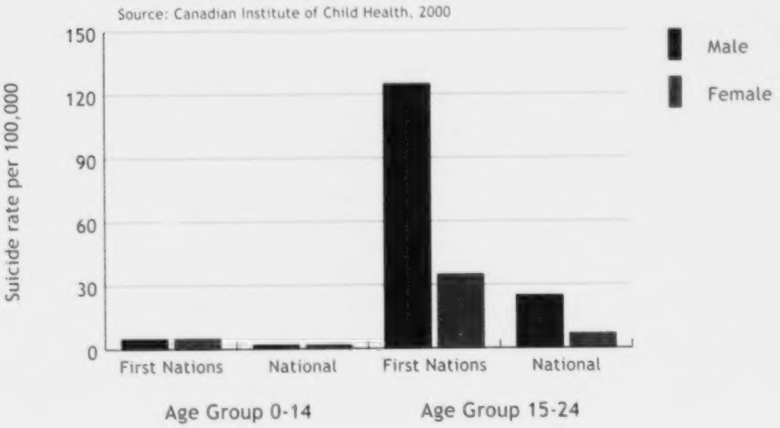

Source: Canadian Institute of Child Health, 2000

Figure 2: Suicide Rates in B.C. 1987-1992

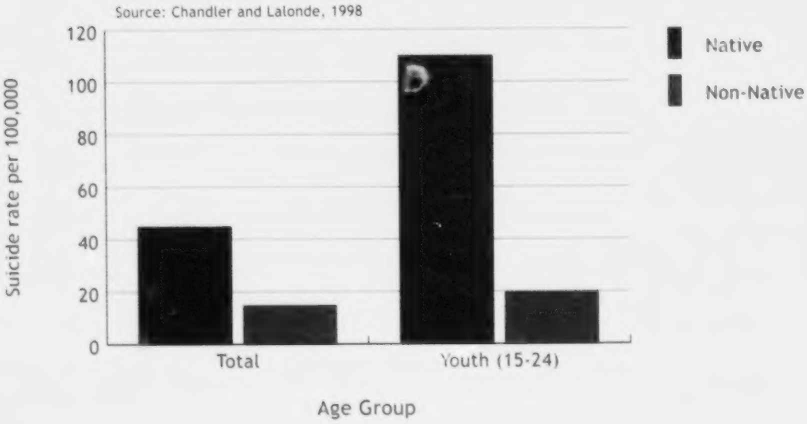
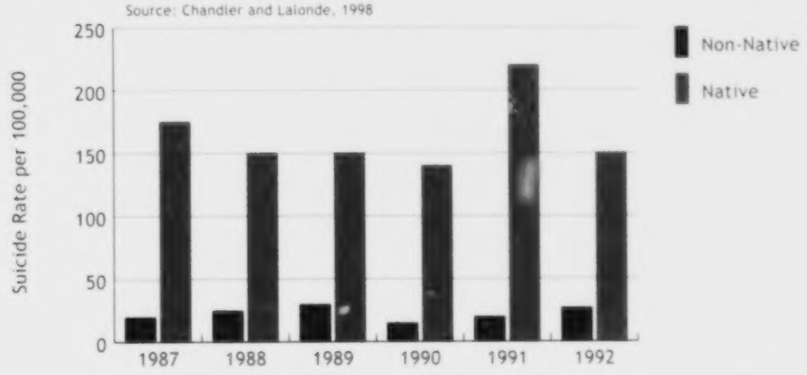

Source: Chandler and Lalonde, 1998

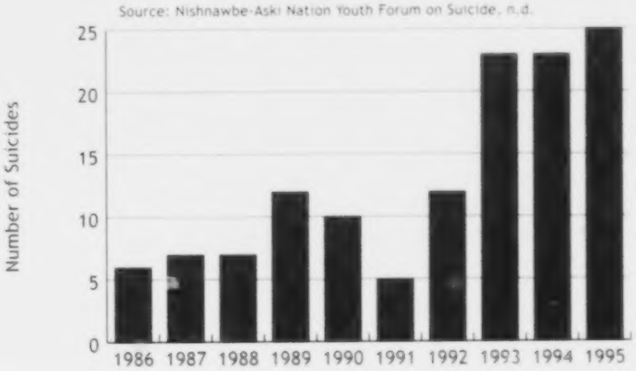
Figure 3: Native and Non-Native Youth Suicide Rates in B.C. (ASMR Age Standardized Mortality Rates 1987-1992)


Source: Chandler and Lalonde, 1998

Suicides are Increasing in Some Communities

Figure 4 shows the dramatic and increasing levels of suicide among the Nishnawbe-Aski youth in northern Ontario. The number jumped from five suicides in 1986, the first year data were available, to 25 in 1995 – an alarming 400 percent increase over the ten-year period shown. Comparable data for southern First Nations are not readily available; however, it would be useful to examine the effects of geographical isolation, remoteness, and other social factors on First Nations youth suicide. Study of variations in rates across communities may provide important clues for suicide prevention.

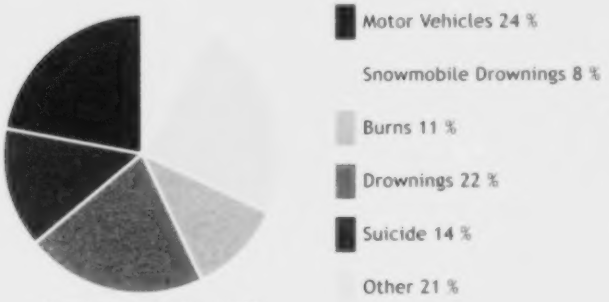
Figure 4: Trends of Completed Suicides Nishnawbe-Aski Nation


Source: Nishnawbe-Aski Nation Youth Forum on Suicide, n.d.

Nishnawbe-Aski Nation Youth Forum on Suicide. 1996. Horizons of Hope: An Empowering Journey. Thunder Bay, Ontario.

In the region of the Eastern James Bay Cree (Quebec), suicides accounted for 14% of total mortality by injury during a ten-year period (Figure 5). Only motor vehicle injuries and drownings caused more deaths than suicide. An unknown proportion of injuries may, in fact, have been suicides unrecognized as such. (The Eastern James Bay Cree suicide rate was no higher than that of the general population of Canada, although the rate did increase during the ten-year period studied.)

Figure 5: Deaths from Suicide and Other Injuries
Cree of Eastern James Bay 1982-92, (n=72)



Source: Cree Injury Study, 1997

Suicide Rates Differ by Tribal Council and Language Group

Although comprehensive information is lacking, there is wide variation in suicide rates across different First Nations communities.[7] A study by Chandler and Lalonde[8] found that suicide rates vary considerably across First Nations communities in B.C. The study reviewed suicide rates over a 5-year period (1987-1992), and found that youth suicide rates vary according to tribal council or community. There were also major differences in suicide rates based on language group. Figures 6 and 7 illustrate the wide variation of youth suicide rates across tribal councils and language groups. This variation suggests the importance of identity risk and protective factors that may account for the differences across communities.

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[7] Kirmayer (1994)

[8] Chandler, M & Lalonde, C. (1998). "Cultural Continuity as a Hedge Against Suicide in Canada's First Nations", Transcultural Psychiatry, Vol. 35(2): 191-219.

Figure 6: Native Youth Suicide Rate by Language Group (B.C.)

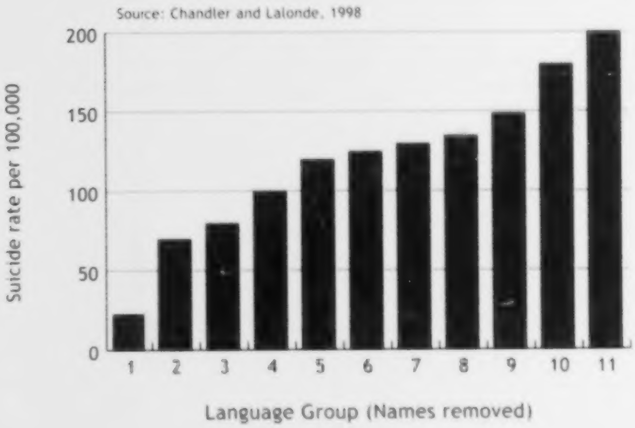
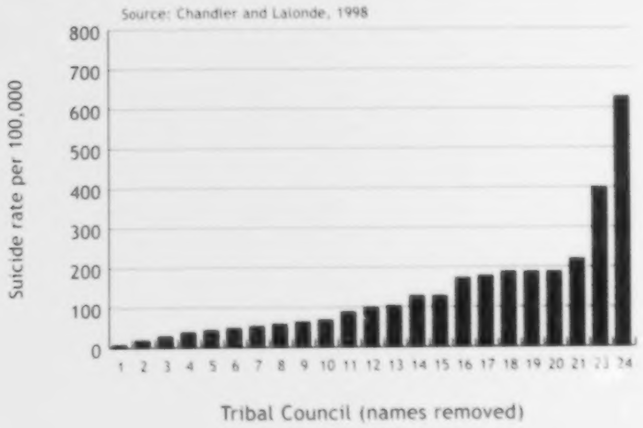

Source: Chandler and Lalonde, 1998

Figure 7: Native Youth Suicide Rate by Tribal Council (B.C.)


Source: Chandler and Lalonde, 1998

Suicides Vary by Cultural Continuity Factors

The Chandler and Lalonde study uncovered clear evidence of a relationship between First Nations youth suicide and the community's control in the following areas, which the authors term cultural continuity:

- self-government
- land claims
- education
- health services
- cultural facilities
- police and fire services

Figure 8 illustrates the compelling inverse relationship between cultural continuity factors and youth suicide. Communities with some measure of self-government in place also had the lowest rates of youth suicide. Land claims and education followed in importance.

Communities with three or more of these factors present experienced substantially fewer suicides (Figure 9). Comparison of communities without any protective factors and those with all six factors, presents a startling picture: 138 suicides per 100,000 versus 2 per 100,000. This has recently been replicated with data covering a 10-year period and additional community-level factors have been identified. Of course, other underlying factors may have contributed to these differences. For example, communities may differ in the levels of available health services (mental, physical, emotional and spiritual) or in the prevalence of various types of health problems. To clarify the implications of this study, further research is essential in other regions and with other measures of social and community factors, as well as mediating factors at the level of individuals' experience.

Lalonde, personal communication.

Figure 8: Youth Suicide Rates by Cultural Continuity Factors (B.C.)

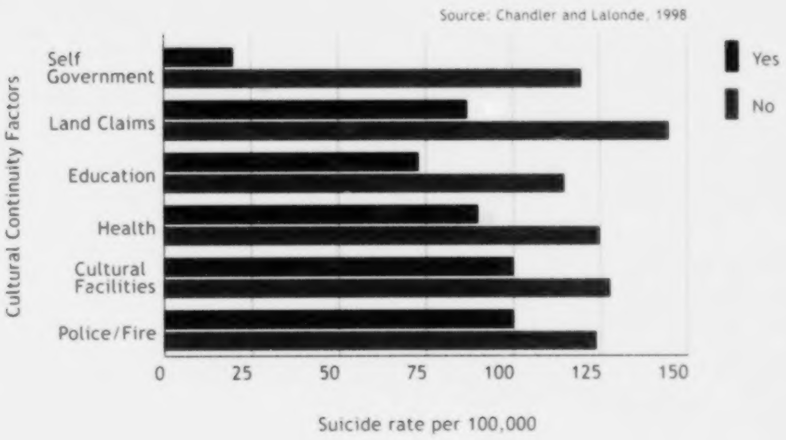
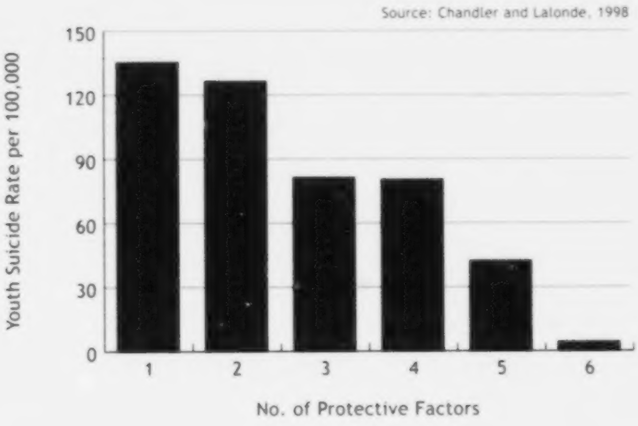

Source: Chandler and Lalonde, 1998

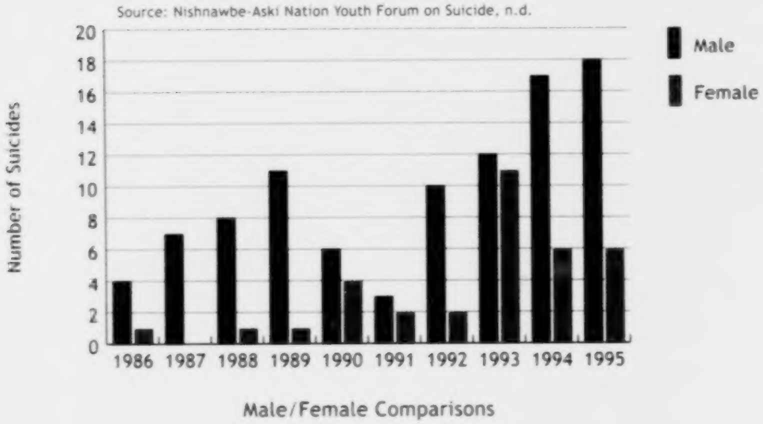
Figure 9: Youth Suicide Rates by No. of Cultural Continuity Factors in Aboriginal Communities, B.C. 1987-1992


Source: Chandler and Lalonde, 1998

Youth Suicide Rates Differ by Gender

Young men commit suicide more frequently than young women — this is true for First Nations and the general population. Males from the Nishnawbe-Aski Nation had a suicide rate five times that of females (Figure 10). A total of 94 males died from suicide compared to 34 females over the same ten-year period (1986-1995). Despite the greater vulnerability of males, young women are also severely affected by suicide. The Canadian Institute of Child Health (see Figure 1) found that young Native women were eight times more likely to commit suicide than their non-Aboriginal cohort. In the same study, young Native men had a rate of suicide that was five times the national average.

Figure 10: Trends of Completed Suicides Nishnawbe-Aski Nation, Male/Female Comparison



Source: Nishnawbe-Aski Nation Youth Forum on Suicide, n.d.

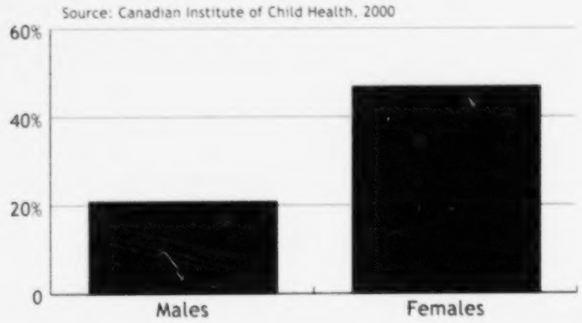
Rates of Depression and Acute Stress are High in First Nations

The RCAP report Choosing Life identified a range of mental health conditions that constitute major risk factors for self-harm. Little detailed data exists about the prevalence of psychological and biological risk factors in First Nations youth or on aspects of self-identity or cultural identity. One study, the First Nations and Inuit

Regional Health Survey [10], found that 18% of children aged 6 to 11 years old had experienced behavioural or emotional problems, and this rate rose to 23% for the 12+ age group.

Evidence from studies in the general population of Canada and the U.S. suggests that depression is the strongest correlate of suicidality. Many First Nations youth report depression, feelings of sadness and loneliness. For example, a Nova Scotia study found almost one quarter of Mi'Kmaq males and almost half the females aged 12 to 18 years have experienced depression and related symptoms. [11] (Figure 11). In the case of the James Bay Cree, most suffered from one or more signs of depression prior to their attempt at suicide (Figure 12). [12] A study using data from the Cree Health Survey found different correlates of emotional distress among males and females, reinforcing the need for a gender-based analysis of suicide risk and prevention. [13]

Figure 11: Percentage of Mi'Kmaq Youth Reporting Sadness or Depression 12-18 Years of Age 1997 (n=87)


Source: Canadian Institute of Child Health, 2000

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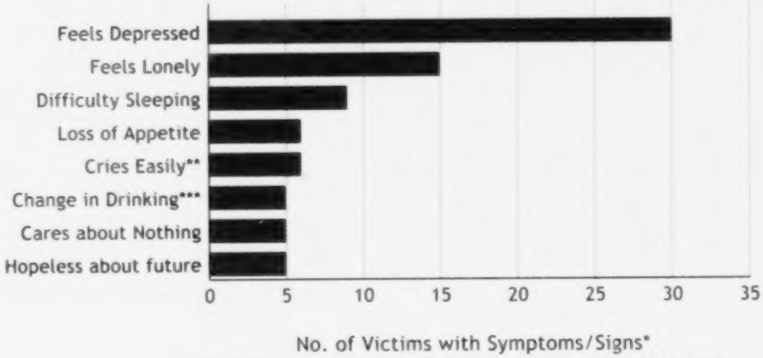
[10] MacMillan HL, Walsh C, Jamieson E, Crawford A, Boyle M. Children's Health. In First Nations and Inuit Regional Health Survey National Report, 1999.

[11] The Health of the Nova Scotia Mi'kmaq Population, quoted in CICH, 2000. [12] Cree Injury Study, op. cit.

[13] Kirmayer, L.J., Boothroyd, L.J., Tanner, A., Adelson, N., Robinson, E., & Oblin, C. (2000). "Psychological Distress among the Cree of James Bay". Transcultural Psychiatry, 37(1), 35-56.

Other than the work of Chandler and Lalonde, there is little information available about the relationship between First Nations youth suicide rates and stresses related to socio-economic indicators of basic needs such as poverty, unemployment, overcrowded housing, access to affordable, nutritious food and clean water. A report on the suicides at Pikangikum echoed the words of many First Nations leaders and mental health practitioners who have stressed the importance of addressing these basic physical needs in order to give First Nations youth a "reason to live". [14]

Figure 12: Hospitalizations for Para-Suicide by Symptoms and Signs Depression, Cree of Eastern James Bay 1982-92, (n=73, 30M, 43F)



Source: Cree Injury Study, 1997

*Multiple or no response possible: 19 with one reported; 15 with 2; 4 with 3; 2 with 4; 2 with 5; 28 with none; **5 or 6 were females; ***all were males

Home is Not a Safe Haven for Many First Nations Youth

For some First Nations youth, home is not a safe place to find respite and healing. Instead, too many First Nations homes are places of violence and too many young people are exposed to violence. Family members facing various stresses are less able to provide a safe haven that meets their children's needs. Figures 13 and 14 summarize some of the acute and chronic stressors reported by Cree youth hospitalized for attempted suicides (para-suicides). Many of these stressors are closely linked to difficulties in the home setting. These stressors, which can contribute to suicide attempts, reflect the many adversities faced by First Nations families and communities.

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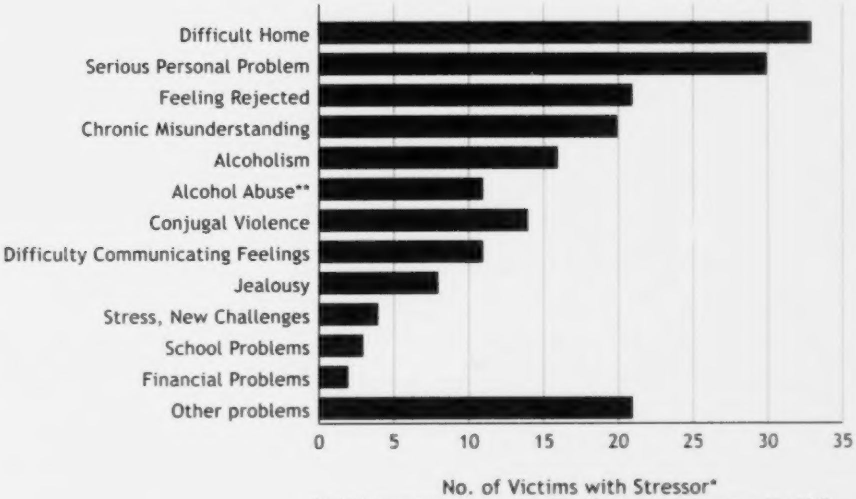
[14] Pikangikum First Nation Report on the Increase in Suicidal Behaviour in 2000 ; Barbara Jo Fidler for Nodin Counselling Service, Sioux Lookout, Ontario.

Figure 13: Hospitalizations for Para-Suicide by Chronic Stressors, Cree of Eastern James Bay 1982-92, (n=73, 30M, 43F)

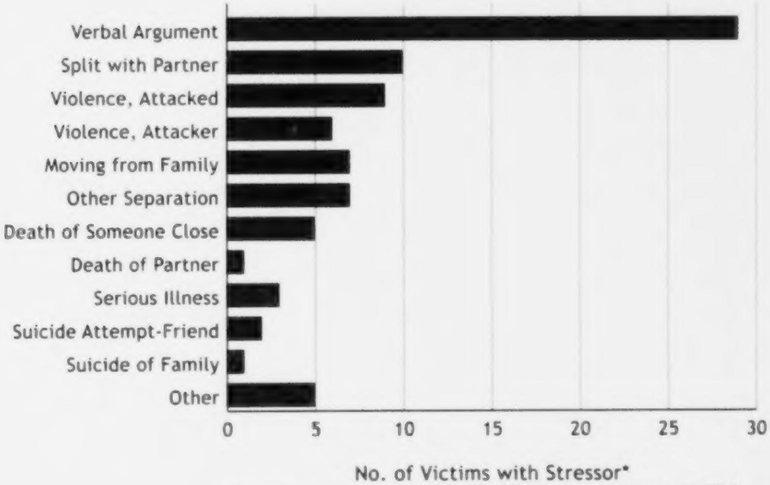
Source: Cree Injury Study, 1997



*Multiple or no response possible: 20 with one reported stressor; 16 with 2; 13 with 3; 5 with 4; 2 with 5; **alcohol abuse by another

Figure 14: Hospitalizations for Para-Suicide by Acute Stressors Cree of Eastern James Bay 1982-92, (n=73, 30M, 43F)

Source: Cree Injury Study, 1997



*Multiple or no response possible: 17 with one reported stressor; 8 with 2; 1 with 3; 47

Recurring Themes in the Literature

Most of the existing literature on First Nations youth suicide describes how the youth experience their day-to-day lives in terms of basic needs and interpersonal relationships, without addressing their broader cultural beliefs and attitudes. While the statistics on previous pages give an overview of what is currently known about First Nations youth suicide in quantifiable terms, they do not tell us what First Nations youth collectively sense about who they are or how they are viewed in the broader world, and whether this is linked in some way to their suicidal thoughts and behaviours (and to how they view and understand suicide itself).

By looking at the problem from both the level of basic everyday needs as well as broader global beliefs, the Advisory Group identified a range of issues faced by First Nations youth relevant to suicide.

Medicalization and the Need for Healthy Partnerships between Biomedical Approaches and Traditional Healing

The contemporary health services of most First Nations normally use a predominantly western medical approach due to the absence of traditional healing practices and/or a lack of funding to support traditional health and healing practices. A medical approach is commonly viewed as the primary way to deal with clinical depression, however, this minimizes traditional healing practices. Depression, suicidal ideation and other mental health and emotional as well as spiritual dilemmas are often linked to many factors, and therefore treatment should be supported equally by biomedicine and traditional medicine approaches.

"Healing" can occur through many different modalities. Where psychiatric and emotional disorders exist (and these are common in suicide victims), active professional psychiatric treatment is called for. When working with suicide victims and those at risk, it is crucial that the full circle of prevention activities (primary prevention, intervention and postvention) offer treatment and support that reflects community beliefs, culture and values.

It is possible to see new ways of preventing youth suicides through concepts such as "cultural continuity", "commitment to future self"[15] and identity.[16] These concepts echo age-old beliefs within First Nations communities. A sense of well being, within a viable cultural identity, is essential in considering approaches to reducing the rate of suicides. The body, mind, heart and spirit can more easily align in full balance and harmony when cultural factors such as original languages, relations with the land, and forms of government are intact or restored. Suicide prevention strategies for First Nations youth must be congruent with cultural beliefs, norms, values and practices and must not undermine these. They must also be assessed in terms of their potential to preserve cultures and identities for future generations.

The Stigma of Emotional and Psychological Distress

Stigma associated with depression, anxiety and other mental health problems often prevents people from seeking and accepting help for treatable conditions. The stigma attached to mental and emotional crises is a key issue that needs to be addressed. The shame and stigma attached to family problems may cause youth to keep silent and, in turn, to reach a point of desperation.

Changing attitudes also determine how suicide is perceived in First Nations communities. For the most part, suicide is such a mark of disgrace or shame for First Nations that they either do not report it at all or they under-report it.

Furthermore, distressed youth often do not seek out mental health services, even in cases where these are available and accessible.

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[15] Chandler and Lalonde, op. cit., and White, J., "Comprehensive Youth Suicide Prevention: A Model for Understanding", Suicide in Canada, eds. Leenaars, A. et al, Toronto, 1998.

[16] O'Connor; Sinclair; NAN Youth Forum Report.

Mental health services may also be perceived as too narrowly focused to be of any real help to young people in crisis who lack personal direction, or they may simply be too public for self-conscious youth to access.

First Nations youths' acts of suicide are often a desperate call for help. Yet the frequency with which youth suicide occurs in some First Nations may lead to complacency about the issue. This normalization of suicide could, in turn, negatively affect the belief systems of the entire community and could itself become an additional risk factor.

Suicide May Occur More Often in Marginalized Groups

Many First Nations youth are perceived and/or perceive themselves to be marginalized in relation to mainstream society as well as within their own communities. Their sense of isolation may be profoundly greater than either that of their non-Aboriginal peers or that of older adults within their communities. This isolation occurs because the traditional belief systems that identify youth as an important stage in the cycle of life are non-existent or have become fragmented in many First Nations. In First Nations families or communities where original cultural teachings and practices have been maintained or restored, there is usually a positive sense of the many roles, social duties and obligations to be fulfilled by the youth. However the experience of many First Nations youth is steeped in social disintegration [17] and conditions associated with marginalization — physical, emotional and sexual abuse, neglect, poverty, substance abuse [18] and deplorable socio-economic standards. Many First Nations youth are feeling the impact of what has been termed "transgenerational grief", carried from the trauma previous generations experienced in residential schools and other forms of cultural oppression. [19] Further, the Aboriginal youth unemployment rate in 1996 was 32 percent — almost double the non-Aboriginal youth rate. [20]

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[17] Kirmayer et. al., and the RCAP report Choosing Life (op. cit.)

[18] Health Canada: Discussion Notes from the Suicide Preventions Workshop: Our Healing Journey, 1994

[19] Jan Longboat, Discussion Notes from the Suicide Prevention Workshop, Health Canada, 1994, p. 16.

Youth in general tend to be more concerned with acceptance within peer relationships than participation within broader community processes. Lack of participation shows up in strained relationships between youth and those who are significant to them. They may be feeling left out even in their own homes because they lack support from their families and other adults. [21] They also may be marginalized because as a First Nations sub-population, their values and concerns are not completely accepted inside or outside their communities. In the first instance, the *Nishnawbe-Aski Youth Forum Report* [22] shows the political, cultural and economic isolation First Nations youth often experience in Ontario First Nations communities. As for youth feeling like outsiders elsewhere, there are numerous accounts of the adjustment problems they face in urban settings, for example when attending urban-based institutions such as colleges and universities.

As emerging adults, youth's values are evolving and they look to community leaders for positive change. In working towards creating these changes, proactive First Nations leaders know that youth need appropriate space and resources in order to also be a part of this process. All youth – especially those most marginalized within each community – need to be seen and heard in the body politic of First Nations communities, to help them to overcome the sense of being denied any voice.

The ripple effect of trauma is powerful in First Nations communities, most of which are close-knit and small in population. Every suicide thus has a direct effect on many community members and this may account for the tendency of suicides to occur in clusters. It is common for victims to be closely related to each other and to

[20] CICH
[21] Health Canada: Discussion Notes from the Suicide Preventions Workshop: Our Healing Journey, 1994
[22] Op cit.

community caregivers. In this case the need for external supports is even greater. Although some First Nations have emergency measures and plans laid out, it is often local volunteer helpers who must respond to suicide victims or victims of injuries, who are likely to be well-known to them. There is often no training or support for volunteer helpers in dealing with post-traumatic stress.

Gender Differences: Why First Nations Suicide Occurs More Often in Males

As outlined earlier in this report, far more young men are committing suicide than are young women. This is true in First Nations communities as well as in mainstream society, although the ratios differ. More thinking about gender roles in today's world might help to shed light on why so many young First Nations men resort to suicide. In many communities, cultural change has led to far more discontinuity in male roles (from hunter and source of food to unemployed) than for women, who continue to raise children and maintain the household. In recent years there has been much debate about the extent to which traditional ways of life and self-reliance within families and communities have been replaced by dependency on government agendas, externally controlled funding and bureaucratic controls. The historical oppression, disruption and disempowerment of First Nations through colonization have been internalized, resulting in 'dysfunctional' dynamics at many interpersonal levels.

De-politicizing the Issue and Politicizing Youth

Suicide among First Nations youth is a political issue involving the Government of Canada, the Assembly of First Nations and First Nations communities and members. Leaders on all sides are expected increasingly to respond to the issue by addressing any and all of the factors that create risks for youth.

Lately, this issue has become a matter of international concern. Certain academic works such as Canada's Tibet: Killing the Innu [23] have also added to the controversy. The international attention given this issue has left many community leaders with the dilemma of whether to work on shaping and sustaining healthy communities outside of the limelight or to call attention to the crisis in the hope of attracting more assistance, knowing that they risk harming the self-image and invading the privacy of community members and thus possibly fuelling further suicides. The devolution of programs and services has added to the bureaucracies within First Nations – another source of alienation among the youth.

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[23] Samson, Wilson and Magower (1999).

First Nations youth would be in a better position to articulate the many challenges in their lives including the reality of high suicide rates in their communities if they could become politicized around this issue and others.

Conclusion

Based on a review of the available literature and other reports and recommendations, the Advisory Group identified four major issues or areas of concern:

- There is a gap in knowledge about what actually works in the area of suicide prevention. With regard to First Nations populations, we lack rigorous evaluations of programs and interventions as well as basic epidemiological information on risk and protective factors at the individual and community levels.

- At the national and regional levels (system-wide), existing mental health services (e.g. access to assessment, consultation and treatment) are inadequate and poorly integrated. Resource distribution is not equitable or consistent. Funding mandates do not respond to communities in crisis; some communities have had to go to the media and present themselves as pathological to get support. Some care providers are not adequately trained or prepared. Holistic integration of health services (physical, mental, emotional and spiritual) is lacking, as is the integration of health in relation to social services, education, etc. There is fragmentation, segmentation and stove piping of services (i.e. they are provided through various federal and provincial departments and funding is allocated separately).

- In many First Nations the issue of suicide is not "owned" for reasons previously outlined. There is a breakdown of many First Nations family units and a need for wholeness and wellness. Care providers need adequate training to be prepared, and many communities have human resources who need to be trained to respond. External agencies and helpers need to engage in a respectful way with First Nations communities in order to build trust and fulfil a responsibility on the part of Canadian society to engage with problems and not simply step back in the name of autonomy. This points to the need for dialogue between First Nations communities and others, and for more support of community-centred approaches.

- At the individual level, there is too much focus on individual pathology and blaming the victim. Suicide is embedded in larger structural problems associated with colonization, including racism and bureaucratic control. There is a need to focus on holistic health at individual, family and community levels. Cultural continuity must be renewed and maintained as a central component of youth identity, self-esteem, hope and being invested in living. The nature of youth peer groups is critical as is their influence. Connection to the emotional self, the land and spirit increases the valuing of life. Positive reasons for living, coping skills, choices and decision-making are essential. When these connections are established and maintained, youth can be integrated within First Nations communities as a valuable asset.

There is a great concern that many useful recommendations from previous initiatives related to prevention of youth suicide have not been acted on, such as those made in the Royal Commission on Aboriginal Peoples Report on suicide.[24] It is crucial that the recommendations in this report serve as a starting point for action, and as the basis for a living document which communities can continue to develop and adapt for their own use.

In an effort to promote action, the next four sections of this report describe the above-noted concerns in greater detail and provide Objectives and Recommendations for dealing with each of these issues. A timeframe is laid out to indicate which recommended actions could be implemented within the next six months (short-term), over the next six months to a year (medium-term) and in the longer-term. Roles and responsibilities of various entities are assigned as much as possible in the recommendations for action.

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[24] RCAP, op. cit.

Section 3

Part 1. Putting Forward an Evidence-Based Approach to Prevention

To address the problem of suicides among First Nations youth, we need to know what works and what does not work. However, the Advisory Group found sizeable gaps in our knowledge about what actually works in the area of suicide prevention.

Recent reports from government and professional advisory groups agree that there is an urgent need for more research to identify effective ways of preventing suicide. Reviews of prevention programs specifically designed to reduce suicide among Aboriginal peoples have found that there are no rigorously evaluated studies to date. Recent research on suicide prevention programs is summarized here (see Appendix D for references).

Research on Current Aboriginal Suicide Prevention Programs

A report published in the spring of 1999 [25] reviewed several Aboriginal programs and set out guidelines for a suicide prevention program that is likely to be effective in Aboriginal communities. The Advisory Group conducted a thorough database search [26], and did not locate any additional peer-reviewed articles describing program evaluations or approaches to preventing suicide among First Nations people. The 1999 review identified 29 suicide prevention and mental health promotion programs developed for, or applicable to, Aboriginal populations based on evaluation documentation from Health Canada. As assessed against the guidelines set out in this report, nine of the 29 programs were recommended as promising or particularly appropriate models for Aboriginal communities who wish to use a pre-existing program.[27]

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[25] Kirmayer, et al, 1999, Suicide Prevention and Mental Health Promotion in First Nations and Inuit Communities, Kirmayer et al., 1999. Culture & Mental Health Research Unit, Institute of Community & Family Psychiatry, Sir Mortimer B. Davis – Jewish General Hospital, Montreal.

[26] Medline, PsychLit, HealthStar and CINAHL databases were searched up to August 2001 using the terms "Indian, North American" or " health services, indigenous" or "Native American" and "suicide" or "attempted suicide."

Other unpublished evaluation reports may also be important to consider. For example, Before the Fact: A Manual of Best Practices in Youth Suicide Prevention, developed at the University of British Columbia[28], summarizes 14 youth suicide prevention strategies[29] and provides a community guide. Preliminary evaluation of the implementation process in seven B.C. communities is available, though no longer-term outcome evaluation has yet been undertaken[30]. This is typical of the field of suicide prevention as a whole: promising programs exist but there is little evidence (such as outcome evaluations), which could help communities, and helpers choose among the many options.

The recent U.S. Surgeon General's *Report on Suicide Prevention*[31] noted this same absence of evaluation research indicating which methods of suicide prevention are effective. The studies that have been done have had methodological limitations, including small sample sizes that may prevent the detection of clinically significant effects.[32]

This lack of information is even more marked for First Nations peoples, despite the high prevalence of suicide in many First Nations communities.[33] Clearly, there is a need for more careful evaluation research over time to determine what works, and how programs and interventions can be adapted to the needs of specific communities.

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[27] Ibid. – a list of nine recommended programs is attached to this report as Appendix D.

[28] White & Jodoin, 1998.

[29] It is important to note that these studies were not specific to First Nations or Aboriginal youth.

[30] Hinbest, 2001.

[31] U.S. Surgeon General, 2001

[32] Arensman et al, 2001; Breton et al., 1998.

[33] Kirmayer et al. 1993; 1999; Middlebrook et al, 2001.

In the absence of empirical evidence of what works, it is necessary to plan interventions based on what makes sense and is compatible with available resources and community aspirations. This pragmatic approach represents current best practices. However, the choice of interventions may be influenced by many forces and potential biases from outside the community. Finding the best plan of action requires an even-handed weighing and balancing of all available and relevant information.

Despite the lack of well-designed studies demonstrating effectiveness, there is some consensus on the elements of a comprehensive approach to suicide prevention. Similar strategies have been outlined in documents prepared by various groups in Canada, Australia and the U.S. The combination of strategies with consultations within First Nations communities provides a basis for immediate action, although the ongoing, rigorous evaluation of what works for First Nations communities must remain a priority.

Current Prevention Practices: Primary, Secondary ("Intervention"), and Tertiary ("Postvention")

Prevention can be seen as circular, involving three interconnected stages. Primary prevention aims to reduce suicide risk by improving the physical, mental, emotional and spiritual health or well being of a population. [34] This has been called "before the fact" intervention. [35] Secondary prevention (early intervention) aims to help with potentially suicidal individuals either before they injure themselves or during a suicidal crisis. Tertiary prevention (or postvention) focuses on people who have been affected by suicidal behaviour: suicide attempters, who are at high risk for a recurrence, and bereaved friends and family members, who are also at risk for increased distress, psychiatric morbidity and the development of suicidal thoughts and behaviours. [36]

[34] Mental Health Branch, 1997; Lester, 1997.

[35] White, 1998.

[36] Kirmayer et al., 1993.

Primary prevention (risk reduction) can be done through programs such as public education, life skills, parenting programs, training of western and traditional/cultural health professionals in suicide assessment and prevention, providing support to families, crisis hot lines and reducing access to lethal means, in particular guns and drugs. Intervention programs include crisis counselling and close supervision and treatment of individuals who have expressed suicidal thoughts. Postvention efforts include counselling and other supports for individuals or groups close to a para-suicide or suicide victim, who might be at risk as a result of the trauma. [37]

Suicide prevention methods can be targeted at different levels: social and cultural settings within the community, family interactions, processes involving vulnerable individuals, or crisis situations. There is general agreement that programs directed to several of these levels at the same time will get the best effects. There is controversy, though, on whether to attempt to influence a whole population or to screen for and target high-risk groups. [38]

In the case of most First Nations communities, their small size and the high prevalence of attempted suicide makes a community-wide approach most appropriate. This has two added advantages: it avoids stigmatizing a specific group of individuals, and it fits with broader goals of community development, which will have a positive effect on the mental health of the whole population as well as vulnerable individuals. Community-wide approaches will be discussed further in Part 3 of this report.

Elements of Effective Suicide Prevention Programs

Suicide prevention generally involves finding ways to reduce risk factors and promote protective (preventive) factors. Risk and protective factors may be understood in terms of individual and collective "resilience", i.e. the ability to spring back from negative conditions. (Resilience is discussed in Part 4).

[37] O'Carroll, Mercy & Steward, 1988.

[38] Rose, 1995.

Research has clearly identified a wide range of suicide risk and protective factors in the general population, most of which apply to First Nations communities [39]. Identified risk factors include:

- Male
- Previous suicide attempt
- Violence victimization
- Violence perpetration
- Alcohol use
- Marijuana use
- School problems
- Mood disorder (i.e. major depression)
- Social isolation
- Poverty, unemployment

Protective factors are especially important in planning prevention that can be addressed to the broader community or cohort of youth. The following have been repeatedly identified as protective factors for youth [40]:

- Perceived parent and family connectedness
- Emotional well-being (especially for females)
- Success at school

There may be some specific risk factors that affect First Nations communities due to their history, social circumstances and challenges [41]. For example:

- Economic marginalization, 'relative misery' [42]
- Rapid culture change and cultural discontinuity [43]
- Forced assimilation

[39] Barney, 2001; Borowsky et al., 1999; 2001; Cleary, 2000; Hawton et al., 2001; Houston et al., 2001; Kirmayer, 1994; Lester, 1997; Santa Mina & Gallup, 1998.

[40] American Academy of Child and Adolescent Psychiatry, 2001; Barney, 2001;

[41] Borowsky et al., 1999; Kirmayer, 1994; Kirmayer et al., 2000; Lester, 1997; Novins, et al., 1999 Borowsky et al., 2001; Malone et al., 2000.

[42] Barber, 2001.

[43] Chandler & Lalonde, 1998

- Forced relocation
- Residential school experience (early separation and loss, forced assimilation, denigration of culture, exposure to violence and abuse), and
- Clustering effects due to the close ties and identification among youth in small communities. [44]

Each First Nations community has experienced its own mixture of these stressors and responded in terms of its own history and culture. Accordingly, interventions must reflect these specifics and be tailor-made for the community.

Ideally, a suicide prevention program for First Nations communities would meet the following criteria: have proven effectiveness, reach high-risk groups, be feasible given local resources, and address both immediate and basic, long-term causes.

The Role of Health Professionals

Studies in the general population in Canada, the U.S. and other countries make it clear that most people who commit suicide have a psychiatric disorder (depression, personality disorder, substance abuse). This suggests that more active medical treatment can reduce suicide and there is some evidence that this is the case in the general population.[45] However, many primary care clinicians are not adequately trained to diagnose and treat suicidal behaviour. In a study in Sweden, most people who died by suicide were not taking antidepressants, suggesting that those with depression had not been adequately treated.[46] Since access to clinical resources is often not available in First Nations communities, the same problem of inadequate treatment is even more likely to occur. In one study in Manitoba, only 6.6% Aboriginal compared to 21.9% non-Aboriginal people had sought psychiatric care prior to suicide.[47]

[44] Wissow et al., 2001.
[45] Rutz, 2001.
[46] Henriksson et. al., 2001.
[47] Malchy, Enns, Young & Cox, 1997

There is evidence that a one-day training program can significantly improve the ability of general practitioners to recognize psychological distress and suicidal ideation among youth, but it is not sufficient to modify their management.[48] In First Nations communities involving people of a different cultural background, this process will probably take longer. Practice audits may prolong the effect. Further, having appropriate training in interventions and support staff would promote effective treatment.

Individuals with life experiences accumulated through similar predicaments such as surviving alcohol and drug abuse or suicide attempts, may have all the requisite knowledge to help others and may tend toward becoming natural counsellors. While such experiences may enhance wisdom, compassion and understanding, they do not necessarily translate into ideal responses to suicidal individuals; there is some evidence that their own past suicide attempt could impair even trained counsellors' ability to respond effectively to their clients.[49] There is a need to nurture potential counsellors through appropriate and effective education and training, mentoring, supervision and support of helpers, be they in clinical settings, crisis hotlines or traditional helping practices.

In remote communities, contact with health professionals may be sporadic. Maintaining long-term contact with previously hospitalized patients may be extremely helpful.[50] The typical pattern of sending people out of remote communities for time-limited treatment may lead to discontinuities in care that put people with chronic problems at greater risk. Strategies for maintaining long-term (even if infrequent) contact between vulnerable individuals and health professionals or other helpers must be developed.

[48] Pfaff, 2001.
[49] Neimeyer, Fortner, & Melby, 2001.
[50] Motto & Bostrom, 2001.

School-Based Strategies

The literature on youth suicide prevention emphasizes that schools should provide a health education curriculum for all students that builds basic skills useful for managing a variety of health and social issues rather than focusing exclusively on the topic of suicide [51]. Such a curriculum would ideally enhance students' ability to cope with stress or distressing emotions (especially anger and depression), problem solving, interpersonal communication and conflict resolution – all measures that help to build self-esteem and deal with emotional conflict and crisis.[52]

Discussion of suicide in the context of developing life skills and self-esteem, problem solving, and communication skills is likely to be more effective than programs directed primarily at suicide per se.[53] Many young people see suicide as a natural or even heroic response to rejection. This misconception, as well as perceived stigma against psychiatric help, can prevent help-seeking for emotional distress.[54] Educational materials aimed at facilitating appropriate help-seeking for major depression, alcohol or substance abuse, and family problems may help to reduce the risk of suicide. Knowledge of Aboriginal culture and pride in one's roots and identity can be promoted through cultural curricula.

Younger children (under the age of 12 years) are also an important target group for primary prevention. This requires attention to, and support for, the family. Family life education, connection to traditional and cultural teachings, family therapy or social network interventions aimed at naming abuse, resolving conflicts and ensuring the emotional support of youth and children, e.g. through culturally sensitive approaches and cultural components in the school curriculum, may be more useful than an individual approach centred on the young person [55]. Protocols can also be established

[51] Kirmayer et al., 1993.
[52] Cimbolic & Jobes, 1990.
[53] RCAP, 1995; Tierney, 1998.
[54] Shaffer et al., 1988.
[55] Kirmayer et al., 1993.

with child protection authorities to respect traditional and cultural ways of dealing with family healing in today's context.

There is some evidence that school-based programs targeted at high-risk youth may be effective in reducing suicidal behaviours and enhancing coping skills for dealing with conflict and anger. A recent study compared two interventions: (i) a brief one-to-one assessment and crisis intervention by a counsellor and, in addition to the individual counselling, (ii) a 12-session weekly small-group intervention based on skills-building and social support.[56] Both interventions were effective in reducing suicidal ideation but the program that included the peer group had broader positive effects, particularly for females.

Community-Based Strategies

There have been very few systematic evaluations of suicide prevention efforts in First Nations communities. Recently, the US Centers for Disease Control[57] (CDC) published a report describing the evaluation of a program implemented in 1990 among an Athabaskan tribe in rural New Mexico that was suffering from a high rate of suicide among youth aged 15 to 19 years. The prevention and intervention program had many facets and included providing mental health and social services that were previously unavailable in the community, as well as measures directed to youth. The program also implemented the CDC guidelines for containing suicide clusters. The level of suicidal acts among youth 15 to 19 years was dramatically reduced almost immediately after the implementation of the program and this improvement was sustained over the following five years. However, there was no comparison community and it is possible that the observed improvement reflected cyclical trends in suicide over time. As well, the number of completed suicides was too small to demonstrate a statistically significant effect of the program. Nevertheless, at present, this is the most rigorous tested program and illustrates all of the principles to be included in an effective community-based approach (see recommended program #1 in Appendix D, Jicarilla Mental Health and Social Services Program).

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[56] Randall et al., 2001; Thompson et al., 2001.

[57] CDC, 1998

A similar strategy was implemented in many Alaska Native communities in 1988. The Community-Based Suicide Prevention Program (Appendix D, recommended program #2) provides grants to communities state-wide to support community-based activities such as cultural heritage instruction, support groups, recreational activities, volunteer helping systems, counselling, and crisis response. An evaluation from 1989 to 1993 found that while project communities began with higher suicide rates than the overall Alaska Native rate, their rates declined faster than the state-wide rate at the end of three years. It appears that communities that have been able to sustain their programs over several years have had the best outcomes[58]. Although the types of programs varied widely, one common element was the active engagement of the community in developing and maintaining the program.

The RCAP report provided case studies of five programs. These case studies serve to highlight factors that contribute to successful mental health promotion strategies among First Nations people. The activities were community-initiated, drew from the traditional knowledge and wisdom of elders, were dependent on consultation with the community, and were broad in focus. Most involved locally-controlled partnerships with external groups. Strategies aimed at community and social development should promote community pride and control, self-esteem and identity, transmission of First Nations knowledge, language and traditions, and methods of addressing social problems that are culturally appropriate.[59]

For the community at large, information about suicide should be transmitted along with information about mental health and illness, help-seeking resources, and ways of dealing with substance abuse,

[58] S. Soule, personal communication to L. Boothroyd (Culture & Mental Health Research Unit), February 1999.

[59] Kirmayer et al., 1993; RCAP, 1995.

anger, relationship break-ups and emotional distress[60]. At the same time, education programs should be sensitive to the fact that suicidality has specific indicators and patterns.[61]

Community caregivers should be knowledgeable about mental health and possess skills in individual and family counselling, social network intervention, and community development. Primary care providers (doctors and nurses) require abilities to recognize and treat major depression and other psychiatric disorders.[62] Other community gate-keepers who can facilitate help-seeking need to be identified and trained.[63] For many youth, peers are essential sources of support and, if trained as peer counsellors, can provide a bridge to professional help when needed.

Although school is a natural focus for programs working with the age groups most strongly affected by suicide in First Nations communities (both the 9 to 12 year olds as well as the teens), there are youth who have dropped out, families who are isolated, and older age groups who may not be reached. Community-based approaches address the need to reach the widest range of individuals and to have impact on the community as a whole with respect to social integration, collective self-esteem and shared vision.

Since breakdown in the transmission of cultural traditions appears to contribute substantially to the widespread demoralization and hopelessness of First Nations youth, the development of programs to transmit traditional knowledge and values, usually by respected elders, is also a crucial component of any suicide prevention program addressed to First Nations peoples.[64]

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[60] Kirmayer et al, 1993.
[61] RCAP, 1995.
[62] Kirmayer et al., 1993.
[63] Capp et al., 2001.
[64] Kirmayer et al., 1993.

Guidelines for Effective Suicide Prevention

In its Special Report on Suicide, the RCAP stressed that only a comprehensive approach to suicide prevention will improve the situation in Aboriginal communities. Such an approach includes plans and programs that provide suicide crisis services, promote broad preventive action and community development and address "long-term needs for self-determination, self-sufficiency and healing."[65]

A suicide prevention strategy with the best chance of making a difference is better conceptualized as a "community wellness" strategy promoting whole person health (physical, mental, emotional and spiritual). This suggests the following guidelines for a suicide prevention strategy:

- Programs should be locally initiated, owned and accountable, embodying the norms and values of the local/regional First Nations culture.

- Suicide prevention should be the responsibility of the entire community, requiring community support and solidarity among family, religious, political or other groups. There should be close collaboration between health, social and education services.

- A focus on the behaviour patterns of children and young people (up to their late 20s) is crucial. This requires involvement of the family and the community.

- The problem of suicide must be addressed from many perspectives, encompassing biological, psychological, socio-cultural and spiritual dimensions of health and well-being.

- Programs that are long-term in focus should be developed along with "crisis" responses.

[65] RCAP, 1995, p.75.

- Evaluation of the impact of prevention strategies is essential.

These guidelines are consistent with recommendations in RCAP[66], other Canadian groups[67], the Australian National Policy[68], the U.S. Surgeon General's *National Strategy for Suicide Prevention*[69], and the guidelines of the American Academy of Child and Adolescent Psychiatry.[70]

Recommended Guidelines

Specific tasks for a comprehensive community-based suicide prevention program are listed below. If pre-existing models are used, programs will require careful adaptation to the specific situation of each community.

Orientation

Suicide prevention should be understood as part of a larger, multi-faceted holistic health promotion strategy that embraces all four aspects of a person as the collective responsibility of the individual, family, community, First Nation or region.

Coordination

A comprehensive suicide prevention program requires a central coordinating group to minimize gaps in the system and to prevent duplication. This group should involve representatives from major sectors of the community: youth, elders, caregivers, professionals (western and cultural/traditional health practitioners, social services, and education), local government, and others. Inter-agency collaboration should be encouraged in order to fully use the strengths of all concerned, resulting in a comprehensive strategy, responsive to the changing needs of individuals and the community. Together they may create or adapt programs that reflect the nature of the community. The immediate effect of such collaboration will be a coordinated response to suicide prevention. The long-term effects will be the strengthening of the community and cultural identity, as well as the emergence of local control, which will improve the health of both individuals, and communities. This coordinating group should also link with and supervise a research team who can help design and carry out evaluations of the prevention activities and programs.

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[66] 1995, op. cit.
[67] White, 1998.
[68] Mental Health Branch, 1997.
[69] 2001, op.cit.
[70] 2001.

Prevention

Based on existing literature, primary prevention strategies for First Nations communities should include:

- Peer counselling in which a group of youth are trained in basic listening skills and are identified as resource people for other youth in crisis;
- A school curriculum that incorporates learning about positive mental, emotional and spiritual health, cultural heritage as a source of healthy ways of coping, the recognition of suicidal behaviour, the danger of substance use and other serious health issues;
- Recreational and sports programs for children and young people to combat boredom and alienation and foster peer support and a sense of belonging;
- Workshops on life skills, problem solving, and communications for children and young people; much of this can be given by youth counsellors who will provide positive role models;
- Family life education and parenting skills workshops for new parents and adults based on culturally sensitive models of roles and responsibilities;

- Support groups for individuals and families at risk (e.g. young mothers, recovering substance abusers, ex-offenders who have returned to the community after serving time);
- Cultural programs and activities for the community at large (e.g., recording and transmitting the traditions of elders, camping, ceremonial feasts, First Nations language courses);
- Collaboration among community workers and cultural/traditional helpers in health, social services and education to promote integration of services;
- Training of lay and professional helpers in health promotion and in physical, mental, emotional and spiritual risk factors for suicide; and,
- Opening lines of communication by creating opportunities for community members to express their concerns and interests (e.g. town council or community meetings and gatherings).

While many of these activities and programs can be implemented through the school or clinic, they would be greatly facilitated by the development of a community drop-in centre (especially for youth) where these activities can take place.

Intervention

The following programs and services address the needs for intervention with individuals at high risk for suicide and should form part of a comprehensive prevention strategy:

- Training of primary care providers (nurses, physicians, social workers, etc.) in suicide risk detection and crisis intervention as well as in the treatment of depression, anxiety disorders, substance use, and other psychiatric disorders;

- Development of a regional crisis hotline. This should be based outside the community to provide some confidentiality. Workers must have knowledge of the community in order to respond appropriately and have community contacts who are available to intervene quickly when necessary;

- Development of a crisis centre. This should be based in the community or in an adjoining community to provide a safe place, "time out", and an opportunity for intensive intervention. It can be staffed by lay helpers such as "big brothers/sisters", with mental health and cultural/traditional professional assistance available;

- Immediate availability of crisis intervention for those at acute risk; and

- Development of assessment and intervention services for parents of youth at risk (e.g., individual, couple or family interventions for substance use, family violence, effects of residential school experiences and relocations, etc.).

Postvention

There is a need for routine follow-up of family and friends who have experienced a loss through suicide, to identify and help those at risk for suicide themselves. Since First Nations communities are often closely knit and many youth find themselves in similar predicaments, suicides frequently occur in clusters. There is a need to develop a crisis team to respond to suicides and suicide clusters. The U.S. CDC has developed guidelines for community response to suicide clusters including the development of a postvention team involving all sectors of the community.[71] These guidelines should be reviewed and modified as required to include cultural/traditional practices and other culturally sensitive responses.

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[71] O'Carroll, Mercy & Steward, 1988.

Evaluation

An evaluation strategy should be developed from the start in parallel with program development. If necessary, this can be done in partnership with academic researchers who have the requisite expertise. Two handbooks on evaluation for First Nations and Inuit communities are recommended for detailed information.[72]

The overall prevention strategy and its major elements should be systematically evaluated in terms of effectiveness; feasibility and cost-effectiveness; process of implementation and maintenance; and wider social and cultural impact. The results of ongoing evaluation can be used to identify useful or detrimental aspects of the strategy, uncover gaps or new possibilities for prevention, and refine the programs. Qualitative and, where possible, quantitative analysis of the wide social impact of the program will add a critical dimension to prevention efforts.

Summary & Objectives

With regard to First Nations populations, we lack information on:

- suicide risk and protective factors at individual, family and community levels that can guide interventions;
- evaluations of programs and interventions showing that they actually prevent suicide;
- effective responses to families and communities that have experienced suicide; and,
- models of integrated professional mental health practices and traditional practices.

Although the problem of youth suicide demands immediate action based on the best available evidence, it is also crucial that new interventions be carefully evaluated so that the best strategies can be identified and widely shared. In the past, collecting information on best practices has been hampered by the stigma of mental illness, a reluctance to consider community aspects, and a concern that the research process does not directly benefit communities. Assisting communities to help themselves and to decide whether to seek outside help requires an understanding of differing community suicide rates and underlying social structural factors. To identify risk factors and develop innovative prevention strategies, the study of multiple communities is warranted; however, making comparisons between communities raises complex ethical and pragmatic issues.

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[72] Health and Welfare Canada, 1991; Humanité Services Planning, 1993.

These considerations lead to the following major objectives:

- Development of capacity for epidemiological and evaluative research in First Nations communities.

- Investigation of risk and protective factors for suicidal behaviour among First Nations youth at the levels of a) individuals, b) families, and c) communities.

- Quantitative and qualitative evaluation of the effects of existing mental health programs and traditional practices on suicidal behaviour, as well as the effects of other programs such as community development and land claims.

- Development and systematic evaluation of innovative suicide prevention programs.

Recommendations

In the short term, it is recommended that:

- Health Canada, the Institute for Aboriginal Peoples' Health (IAPH, of the Canadian Institutes of Health Research) and other national and regional organizations place a high priority on research related to First Nations suicide, find and earmark new funding for this research and issue a special call for proposals.

- Health Canada, the Assembly of First Nations (AFN) and other agencies, ensure that any future suicide prevention programs contain an independent, systematic evaluation component.

- Pilot studies and demonstration projects have clear objectives and a plan for the next stage of development that can be used to guide subsequent program development.

- The IAPH set up a national coordinating group for research into mental health, psychiatric disorders and suicide prevention, to:

  a) encourage surveys and evaluations to be conducted in a manner that allows pooling of data and comparisons across communities and regions;

  b) collaborate with local groups in conducting well-designed studies on epidemiology and outcome evaluation; and,

  c) encourage the sharing of data and dissemination of findings as a means of providing public education and increasing community awareness (see Appendix H, Figure 1).

In the long term, it is recommended that:

- Health Canada link with the IAPH, AFN, National Aboriginal Health Organization (NAHO), the Native Mental Health Association of Canada (NMHAC), the Aboriginal Nurses Association of Canada (ANAC), and other organizations to convene a national conference on suicide prevention which would advance the discussion on suicide, transfer skill sets, offer workshops on how to collect data and conduct evaluations and educate communities on the benefits of open sharing of epidemiological and evaluative data.

- The IAPH and NAHO create a national clearinghouse and website for information on best practice models and culturally sensitive methods of health research and evaluation in Aboriginal communities and populations. This should be linked to similar groups and sites working in the U.S., Australia, New Zealand and other countries to address mental health issues with Aboriginal peoples.

Part 2: Toward Effective, Integrated Health Care at National and Regional Levels

This section addresses the organization of mental health care services for First Nations peoples. The division of powers in the *Constitution Act, 1867*, section 91(24) assigned to the federal government jurisdiction over Indians and lands reserved for Indians. Health Canada, through the First Nations and Inuit Health Branch (formerly Medical Services Branch), has provided for the health care needs of First Nations citizens through financial contributions. However, no clear mandate for the provision of mental health services has been established.

Description of Existing Programs

The First Nations and Inuit Health Branch (FNIHB) has the mandate to deliver a number of programs, which include a mental health component. Currently, the four FNIHB funding streams for mental health-related services are: 1) Brighter Futures Initiative (BFI), 2) Building Healthy Communities (BHC), 3) National Native Alcohol and Drug Abuse Program (NNADAP) and 4) Non-Insured Health Benefits Program – Crisis Intervention / Mental Health Counselling (NIHB). Various mental health services for First Nations peoples are provided through one or more of these programs.

BFI, implemented as of 1993, and BHC initiated in 1994, are both delivered by First Nations at the community level. In addition, NIHB provides for short term, crisis intervention counselling. Although these programs have been in existence for many years and have considerable resources attached to them, they have not been evaluated since their inception. It would be difficult (but not impossible) to assess their effectiveness. Appendix E shows the approximate expenditures for the BFI, BHC and the NIHB Programs in the 2001-2002 fiscal year. It should be noted that the BFI and

BHC dollars shown in Appendix E do not reflect the funding provided to transferred communities.[73]

BFI is intended to support community-based activities, within a community development framework that fosters the well being of the First Nations children, their families and communities. BFI provides programming such as mental health, child development, parenting skills, healthy babies, injury prevention and solvent abuse treatment. BHC is intended to support the development of specialized community-based mental health treatment services, crisis intervention services and solvent abuse programming.

As outlined in Part 1, substance abuse is a risk factor for suicide. NNADAP began in 1984; the majority of First Nations communities have at least one NNADAP worker in the community and the Residential Treatment Component has a national network of 53 treatment centres (695 treatment beds) operated by First Nations organizations and/or communities to provide culturally appropriate in-patient and out-patient treatment services for alcohol and other substance abusers. The financial resources expended in the provision of the NNADAP in the 2001-2002 fiscal year are also provided in Appendix E.

The purpose of the NIHB Program is to provide fiscally sustainable health services appropriate to First Nations' unique health needs, aimed at achieving a health status comparable to non-Aboriginal Canada in similar living contexts. NIHB Program funding is intended to "provide limited funding of last resort for professional mental health treatment for individuals and communities in at-risk, crisis situations"[74].

Benefits under the NIHB Program include: pharmacy (including prescription and over-the-counter medications, medical supplies and equipment), dental care, vision care, transportation to access medical services, health care premiums in Alberta and British Columbia only, and other health care services including crisis intervention mental health counselling[75]. To maintain quality of care and accountability of service, NIHB-funded mental health services are provided by mental health professionals, including those in the disciplines of psychology, psychiatric nursing and social work.[76] Mental health counselling is included in the NIHB 'other health care' category and accounts for $8.9 million, just over half of the $16.1 million budgeted in 1999/00, despite being mandated to respond to both individuals and communities in crisis. In comparison for the same year (1999/00), almost $4.5 million was spent on benzodiazepines (antianxiety medication) alone for the same eligible population.

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[73] Many First Nations have signed "transfer" agreements with Health Canada, which transfer control over health services from the federal government to the First Nations.
[74] NIHB Interim Program Directive, No. 7, Mental Health Services, Preamble, p.1.

Problems with Existing Programs

In examining issues related to the state of existing services, a number of problems are evident. One major area has to do with the NIHB mental health crisis intervention program. Coverage of basic mental health services for First Nations appears to be inadequate; while some types of services are provided, others are not. This can lead to a greater emphasis on medication than other treatment approaches such as counselling. Communities in crisis as a result of completed and attempted suicides are the intended beneficiaries of NIHB mental health crisis intervention, however, there are several problems related to the use of this service:

- According to the Interim Program Directive, NIHB funds may be accessed by specific communities in crisis situations or at high risk, but it is not known to what extent and with what frequency these resources are utilized for this purpose.

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[75] NIHB 1999/2000 Annual Report, p.3.
[76] NIHB Interim Program Directive, p.1.

- The number of counselling sessions available per client varies by region and in some cases, there have been reductions imposed on the maximum number of sessions that a client would be funded to receive.

- There have been issues raised regarding the timeliness of approvals for counselling sessions, thereby allowing for the crisis to "pass" before counselling is initiated.

- In some regions, the process of applying for approval of sessions is considered both labour- and paper-intensive.

- There are issues around eligibility for services and how one is registered on the status verification system (FNIHB database of all clients eligible to receive NIHB benefits).

- There are issues related to individuals who live on- or off-reserve in terms of their ability to access services; for example, if NIHB-funded counsellors practice off-reserve, there may be difficulties in travelling to/attending counselling sessions.

- Some clients may feel that the counselling they do receive is not culturally sensitive or culturally relevant.

- Youth in particular may feel that they are unable to 'relate to' the counsellors available to them thereby affecting their ability to establish a therapeutic alliance and/or to comply with counselling.

- Counsellors may vary in their ability to deliver effective, evidence-based mental health services and to advocate for clients with specialized mental health needs.

- NIHB-funded counsellors may vary in terms of their perceived comfort/confidence in dealing with difficult patients including those who are acutely suicidal.

- Counsellors may be forced out of necessity or urgency to use the counselling sessions in ways that they are not intended (i.e. for other than short-term crisis intervention; or in some cases, doubling up on the number of sessions actually funded for). In some situations, this may lead to 'burn-out' of the counsellor who tries to do too much with too little resources.

- Confidentiality is an important concern for individuals considering entering into a counselling relationship and becomes even more critical in smaller communities.

- Individuals who have complicated histories and multiple mental health issues (e.g. relationship and family difficulties, concurrent substance abuse, domestic violence, criminal history) may be receiving services from multiple agencies which results in a fragmentation and a lack of coordination of their care.

- There is regional variation on how the NIHB directive is interpreted which is related to what services are delivered; for example, the directive implies that funding is available for individuals and communities in at-risk, crisis situations. This tends to benefit the communities with the greatest capability to access these sources of funding and services and is a barrier to the provision of better-integrated services.

The Non-Insured Mental Health mandate policy directive covers "communities in at-risk, crisis situations" where "there is a diagnosis and treatment plan for the individual or the community describing estimated duration of treatment and estimated costs per the service provider(s)". The methods of service can include "MSB contracts with mental health therapists" and "contribution agreement(s) with First Nations"[77]. In effect, this directive allows for a differential response to communities in crisis, based on their needs as evidenced by suicides and crises. Current implementation does not reflect a "same policy approach". In fact, there are major funding variations in response to communities with similar rates of suicide (e.g. $140 versus $3.00 per person) in the same region.

A second major issue involves the 'stove-piping' of funding streams. FNIHB services tend to be fragmented into different bureaucratically defined domains. This is a barrier to well-integrated services. It also tends to benefit the communities with the most resources and the greatest capability to access various sources of funding. In addition to FNIHB resources, many First Nations communities have been successful in accessing funding from the Aboriginal Healing Foundation (but this is time-limited funding and after next year no new projects will be funded). Provincial governments also receive funding to provide mental health services to all of their provincial residents (although it is not known how well First Nations people access these services).

Suicide rates vary widely from one First Nations community to another. The impact of a suicide outbreak can be devastating.[78] Resources tend to go to communities best able to command attention (through media or other political activity), rather than based on more valid measures of need applied equitably. The system needs to be reconfigured to offer support not only to communities capable of making formal applications for resources, but also those in greater disarray and without means to mount an effective appeal.

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[77] First Nations and Inuit Health Branch Interim Program Directive for Mental Health Services, 1994.
[78] RCAP op. cit., p.11.

Variations exist between provinces/regions with regards to provincially funded services and NIHB mental health services. BFI/BHC/NNADAP initiatives are mainly per-capita formula driven. The outcome of this uncoordinated distribution of funding and services results in First Nations with higher rates of suicide not receiving access to funding or services reflective of their needs. Currently, a mechanism does not exist for communities at high-risk or in crisis to ensure an adequate response from the various levels of government (provincial and federal). Community workers with few resources, skills and insufficient team support often are left to deal with the most difficult problem situations at the individual and community levels.

There are no NIHB utilization data available for specific 'hot spot' communities or communities considered at high-risk for youth suicides at this time. Most studies have only addressed factors at the level of individual needs. Gathering further information on factors indicating communities at risk will require study of multiple communities within the same time frame.[79]

In the past, FNIHB has not taken steps to identify communities at high risk for suicides. Overall, the Branch has tended to be reactive, through belated responses to crises based on media coverage, rather than proactively identifying problems at an earlier stage. The current situation is that crises usually become widely known through media coverage and this in turn spurs efforts to repair a longstanding situation, often with short-term interventions directed exclusively to the crisis and not to its underlying social structural causes.

Much of the existing 'hard data' does not provide an accurate representation of the amount and quality of services provided through the NIHB Program; therefore, the implications for suicide prevention cannot be definitively inferred.

[79] Kirmayer, L.J., Fletcher, C. & Boothroyd, L.J., 1998 - Suicide Among the Inuit of Canada. In Leenaars, A.A. et. al., (Eds.) Suicide in Canada, Toronto (Ontario): University of Toronto Press. Page 194.

There are inter- and intra-regional differences in the utilization of NIHB resources, which also impede clarity regarding effective and integrated services nationally and across regions. This variation partly depends on how regions have interpreted the Interim Program Directive (i.e. services are directed solely at individuals).

Roots of the Problem

The funding allocations from the BFI, BHC and NIHB Mental Health Crisis Intervention do not appear to be driven by community mental health needs – particularly not for communities in crisis as a result of suicides. Underlying roots or origins of the problem include lack of mandate for mental health, federal/provincial jurisdictional issues, lack of coordinated national plan, lack of strategies for identifying problems at an early stage, and lack of support and remuneration for appropriate mental health services.

Most importantly, at present, there is no national mental health mandate for First Nations. Because there is no mandate, it follows that there are no comprehensive policies or national mental health programs.

The use of a per-capita funding formula (i.e. a "same policy approach" for BF and BHC funding) may actually be contributing to social structural disparities between those First Nations communities that are relatively healthy and those that are typically in crisis. Funding is formula-driven rather than needs-driven. One consequence of this "same policy approach" is that it enables communities with lower suicide rates to fund "primary prevention" activities such as health promotion workshops, while communities with high rates of suicide are required to use this funding for "tertiary" level prevention, i.e. suicide postvention.

Solutions

In order for the FNIHB to take progressive action in addressing communities in crisis due to suicides or suicide attempts, a community crisis assessment guideline based on preconditions and risk factors needs to be developed and tested (see Appendix F, a draft assessment tool).

A review of the current services and practices flowing from existing mandates would assist efforts to coordinate, integrate and optimize existing mental health services intended to address the First Nations youth suicide tragedy, by identifying gaps and overlaps.

The Suicide Prevention Advisory Group suggests the following objectives to direct services at the national and regional levels toward a more integrated and effective system.

Summary and Objectives

- To establish a national mental health mandate for First Nations.

- To increase funding for mental health services, based on both the western medical model and traditional healing approaches, in all First Nations communities.

- To develop the capability of Health Canada's FNIHB (at both the national and regional levels) and the AFN to respond to communities in emergent crisis situations before the media draw attention to these situations – and not be dependent on the media to draw attention to the problems.

- To develop a monitoring system at the national level to track communities in terms of their level of risk and degree of crisis on an ongoing basis.

- To address the maldistribution of existing funds so that communities are not required to present, and to maintain, an image of hopelessness and pathology in order to access resources (services and support).

- To ensure that community mental health and cultural/traditional practitioners and workers have adequate resources and support and access to current information on best practices.

- To ensure that community mental health, cultural/traditional practitioners and addictions services work in a more coordinated and collaborative way and also include social services, education services etc. such that communities and their members receive more integrated health care consistent with Aboriginal views of health and wellness.

- To ensure that mental health and addictions programs are more proactive in their approach to clients considered at high risk of self-harm or suicide through community outreach approaches.

Recommendations

In the short term, it is recommended that:

- The mandate of the Non-Insured Health Benefits (NIHB) program, as outlined in the "Interim Program Directive for Mental Health Services" (March 1994), be reviewed and evaluated by the FNIHB and AFN to determine how well it is meeting the needs of communities in crisis.

- NIHB funding for mental health services be increased and funding for traditional practitioners be established. Further, that Regional Offices of FNIHB encourage more latitude and a broader interpretation of the NIHB Program

Directive for Mental Health Services to allow for greater access to services on-reserve in all regions.

- A demonstration project of the "Community Crisis Assessment Guideline" (see draft guideline, Appendix F) be undertaken to involve communities in a process that will identify preconditions for suicide and determine their level of risk for suicides.

- Health Canada earmark funding for the development of educational materials that are both culturally sensitive and relevant (e.g. videos, posters, pamphlets). The materials would address issues such as help-seeking for depression or crises as well as promotion of positive mental health and wellness.

In the medium term, it is recommended that:

- Health Canada initiate and support the creation of a comprehensive national First Nations mental health strategy (including a mandate, policies and programs) that integrates approaches to suicides, psychiatric disorders and other critical mental, physical, emotional and spiritual problems in First Nations communities.

- Current funding allocation methods (e.g. proposal-driven or per capita) be altered so that funding for mental health services in First Nations communities is based on verified need as determined by a standardized assessment process. A program review, based on intended client and community outcomes, will form the basis for decision-making regarding future funding.

- Psychotropic medication utilization patterns be reviewed and evaluated by FNIHB in collaboration with AFN and a clinical consultant, in relation to current expenditures. This evaluation can determine whether antidepressants and other medications are being used appropriately and whether some portion of the NIHB budget should be redirected to non-pharmacological interventions.

- Mental health, holistic health, and social services workers be trained in case management, case conferencing, and other models that support integrated client services and collaborative interdisciplinary teamwork. In addition, these workers be further educated in techniques of suicide prevention, recognizing signs of depression, doing suicide risk assessment, and using community outreach approaches. That this training be provided by Health Canada, in collaboration with the AFN.

- Designated professionals, including physicians, working in First Nations communities, be remunerated on a per diem basis (vs. fee-for-service) to encourage increased clinical supervision, multidisciplinary case conferencing, case management and collaborative teamwork approaches.

- Health Canada design and implement a national crisis consultation service to identify communities at high-risk for suicides. For example, a community profile system can be developed nationally to assist communities to assess their psychological and social status, and use of all national and provincial mental health-related funding and other services (e.g. BFI, BHC, NIHB, NNADAP, Aboriginal Healing Foundation, CFS etc.).

- When communities are identified as being in crisis through this community assessment system, efforts be made to optimize health resources required, and available and accessible in, and to, that community. This assessment should be framed and described in positive, constructive terms for the community. Those communities at high risk for suicides should be offered professional mental health and cultural/traditional health services on a proactive basis before full-blown crises develop.

- That Health Canada fund the creation and management of a national resource bank of mental health practitioners, including traditional healers, with substantial experience in First Nations crisis intervention, suicide prevention and clinical practice and/or research. This group would meet on a regular basis to review progress in the area of crisis intervention, suicide prevention and postvention, to advise FNIHB and AFN, and to develop a collegial support network that would be available to community workers.

In the long term, it is recommended that:

- The national resource bank develop and implement a plan to support community workers through ongoing consultation, networking and follow-up using available technologies (e.g. on-site visits by invitation, internet/website, telepsychiatry, multimedia materials etc.). Such a plan would include a training/apprenticeship program. There would be a reciprocal flow of communication between the resource bank and the community workers that would provide updated information for the community profiles.

Part 3. The Importance of Community-Driven Approaches

Introduction

The predicament of contemporary Aboriginal youth cannot be separated from the problems that have beset their communities as part of the legacy of colonialism. RCAP argued that colonization resulted in a historical power imbalance, concluding that high suicide rates among Aboriginal people are a result of severe social and cultural disorganization.[80] Aboriginal peoples' loss of control over their lives and lands has contributed to a host of social, political and economic problems in communities. Given this history, it is crucial that any program designed to prevent First Nations youth suicide should attempt to increase the sense of ownership and self-determination on the part of Aboriginal communities.[81]

Community management and ownership over the development and implementation of suicide prevention programs is a significant theme in the literature on Aboriginal health. Local control has been identified as a key element in the success of various programs designed to address alcohol and drug addiction, suicide, and family violence[82], and a key aspect of the successful Community-Based Suicide Prevention Program (CBSPP) currently operating in Alaska.[83] RCAP recommended that local Aboriginal communities take responsibility for the design of the overall strategy and the delivery of programs geared to prevent suicide.[84]

The idea that the solution cannot be "borrowed or imposed from outside agencies or other communities" was also clearly voiced by Aboriginal youth attending the Nishnawbe-Aski Nation Youth Forum on Suicide.[85] As Dion Stout and Kipling note:

[80] RCAP, op. cit.
[81] See Appendix G for a definition of community and for a summary of current approaches to community development.
[82] Davis - 1999 p. 15.
[83] Davis - 1999 p. 33-35, op. cit. in Part One (see recommended program # 2 in App. D).
[84] RCAP, op. cit.
[85] Nishnawbe- Aski Nation Youth Forum on Suicide, 1995 (op. cit.), p. 31.

> ...surveillance, prevention and crisis intervention programs in the North must be expanded, with a strong focus on initiatives that are designed and implemented by communities themselves.[86]

It follows that community involvement in developing a program response to the issue of suicide is as important as the actual program that is developed. Communities themselves must be supported in taking control of that process.

Why Engage the Community?

There are both ethical and practical reasons why government and professionals working on suicide prevention must engage First Nations communities:

- To impose a program on First Nations that they have not developed would simply perpetuate the colonial approaches of the past and maintain current and historical power imbalances.

- To support communities in taking control of, and sustaining, the process and programs they need to prevent youth suicide is the best way to ensure that: programs will be broad in scope and tailored to the needs of the individual community; address some of the underlying cause of suicide; and incorporate all stages and levels of prevention in programs that are developed.

Broad in Scope and Tailored to the Needs of the Community

As noted in Part 1, approximately 15 evaluative studies[87] have been conducted in Canada on suicide prevention programs. Most of these studies involve school-based programs. In reviewing these studies, Breton and colleagues noted that those programs that focus only on one sector, such as schools, did not reflect the reality of a youth's experience. In the course of his or her daily life, a young person comes into contact with a range of institutions and social groups (i.e. school, family, the community at large etc.). In order to be effective and reach the broadest range of youth, therefore, a suicide prevention program must cover all aspects of a young person's life.

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[86] Madeleine Dion Stout and Gregory D. Kipling, 1999, p. 15.

[87] As noted earlier, these studies are not specifically focused on First Nations or Aboriginal youth.

Deal with the Underlying Causes of Suicide

Suicide is often characterized as a symptom or sign of a problem, rather than being seen as a significant problem in and of itself. In order to treat the underlying loss or lack of power and control that contributes to suicidal behaviour, programs must do more than simply attend to the symptom. This means that a prevention program cannot focus solely on crisis response, but must be designed as a long-term developmental undertaking and provide a range of prevention programming.

This long-term developmental undertaking occurs in the social context of the community, identified as a key setting for health promotion interventions.[88] The social structure of the community is identified as important to the development of youth potential.[89] Participatory community development processes can work to build new linkages and to strengthen existing linkages across those facets of the community that are responsible for the socialization of youth, such as the family, the school, the peer group, sports and non-sports related clubs and organizations to which youth may belong. A strong community system is characterized by many linkages between the different socializing contexts to which the youth belong.[90]

Involve all Stages and Levels of Prevention

While some programs offer a measure of control to the local authorities, a sense of ownership and investment in the program can only be guaranteed when the program is developed with, and by, First Nations. To develop a suicide prevention program tailored to the specific needs of a community, it stands to reason that the members of the community can, and should contribute vital information for serious consideration and decision-making.

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[88] Hawe, 1994; Poland et al., 2000.

[89] Garbarino, 1985.

[90] Ibid.

Community involvement is necessary in order to tailor programs to the specific needs of a community, and support local investment in, and control of, the program. Engaging the community can be seen as the keystone in a process designed to develop a comprehensive suicide prevention program.

Meaningful Involvement of Youth

The World Health Organization views youth as resources and assets to the community and encourages their active participation in the promotion of their health.[91] The Canadian Council on Social Development reinforces this view in stating that:

> [E]very child deserves an equal chance to develop his or her full potential, and that our future depends on the ability of our young people to meet the demands of a complex society and a volatile community[92].

This view converges with the national goals for healthy child and youth development aimed at promoting and protecting their health and well-being through capacity-building and providing youth with meaningful opportunities for participation.[93]

Health promotion challenges traditional meanings of participation and health for the implementation of prevention interventions at the community level. The term "empowerment" signals a shift from a top-down approach to the design, implementation and evaluation of categorical health problems to organizational and community processes aimed at engaging people of all ages in

[91] World Health Organization, 1993.
[92] Canadian Council on Social Development, 1996.
[93] Health Canada, 1997.

decisions that affect them in the context of their everyday lives.[94] This implies that adolescents should be engaged as active participants in the planning and implementation of activities related to their health, rather than passive recipients of adult-designed and implemented programs.

Contemporary approaches to adolescent health view the active participation of youth in their social environment as key to the realization of their potential[95]. Developing youth potential through active participation can be nurtured through a partnering process with adults that is inherently capacity building.[96] As capacity-builders, adults take on additional roles of mentoring youth[97] and facilitating their active participation in decision-making[98]. This can provide youth with opportunities to increase their knowledge and skills, and in turn, develop their sense of self and place in the community by being included in their social milieu in a meaningful way.[99]

How Best to Engage the Community

The literature points to community development processes and techniques as a means of allowing and supporting local ownership and control to take place.[100] The most important aspect of community development relative to suicide prevention is that it empowers people to come together, act purposefully, and take control of their lives. Furthermore, it allows interventions to be tailored to the particular needs and circumstances of a community; helps develop support among community members for the interventions; and increases the likelihood that initiatives will be sustained.

[94] Green, 1986; Green, 1999.
[95] Blyth & Roehlkepartain, 1995; Geraghty & Roehlkepartain, 1995; Takanishi, 1993a.
[96] MacDonald & Green, in press.
[97] Ringwalt, Graham, Pascall, Flewelling, & Browne, 1996.
[98] Wallerstein, 1992.
[99] Cargo, 1998; Chinman & Linney, 1998.
[100] Royal Commission on Aboriginal Peoples, 1995, p. 105.

In the absence of evaluation studies of community development as an intervention for suicide prevention, a number of questions regarding best practices remain:

- What are the best methods for engaging communities?
- What are the best tools to use in a given situation?
- How can we build capacity for community development within First Nations communities?
- Where and how does the community development process fit with, inform or interact with clinical interventions?
- How can we evaluate the impact of community development practices on suicide?

It is also important to recognize that the needs of communities vary depending on the stage they are at in experiencing and responding to suicide. The members of a community that has experienced a recent suicide will be in a different frame of mind, and have different needs than those in a community that has suffered such an experience some time ago. The appropriate and effective community development approach will differ for a community "at risk", a community in crisis, and a "healthy" community.

The participation of youth in the community development process must also be given special consideration so that the process actually does engage them. As a period of individual development, adolescence is framed most often as a period of risk, rather than opportunity.[101] To some extent, adolescent health has become synonymous with the concepts of "risk" and "risk behaviour."[102] This has the consequence of stigmatizing youth as social problems in need of fixing rather than focusing on the social situations that contribute to the vulnerability and resilience of youth[103]

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[101] Albee, 1981; Rappaport, 1981; Takanishi, 1993a; Takanishi, 1993b.

[102] Jessor, 1991; Jessor, 1993.

Intervention programs that place the origins of problems in the individual or their culture are referred to as models based on deficits[104] or needs.[105] More recent approaches to adolescent health build on assets or strengths-based models of positive health aiming to develop youth potential.[106] These approaches, framed in the literature as 'positive youth development', share an emphasis on factors in the family, the community and the larger society that interact to shape youth identity within contemporary society. Adults, and particularly parents, are responsible for creating the environments that support the healthy development of children. Attention to youth suicide, therefore, must begin with the positive parenting of young children.

Summary and Objectives

Given the challenge of developing programs that can be tailored to individual communities in addressing the underlying causes of suicide and involving youth in meaningful ways, there is a need for demonstration projects, prior to investing in a nation-wide program. Two types of demonstration projects are recommended.

The first type of project involves interventions that can be developed in the short- to medium-term. An example is community-based suicide postvention. The aim is to use the dilemma of suicide to promote community cohesion and a coordinated response to suicide risk. Community development processes would engage the community for the purpose of developing interventions that utilize the community's existing abilities, resources and strengths to help youth at risk.

[103] Madison, 2000; Mertens, 2001
[104] Madison, 2000
[105] Albee, 1981; Rappaport, 1981.
[106] Blyth & Leffert, 1995; Blyth & Roehlkepartain, 1995; Lerner, 1995; National Clearinghouse on Children and Youth, 1996; Zeldin & Price, 1995.

The second type of project would focus on longer-term efforts at more basic community development and the integration of youth. All community development processes used should be structured to involve the people and institutions of a local geographic community, and address all aspects of community life-social, economic and cultural.

Overall, the goal is to identify an effective process and mechanisms to support communities in taking control of, and sustaining, the process and programs they need to prevent their youth from committing suicide.

Recommendations

In the short term, it is recommended that:

- Health Canada make available to communities guidelines and links to resources (resource people, printed materials, networking with other communities or professionals) for developing a community-based postvention program (following guidelines based on the U.S. Centers for Disease Control) which can provide a basis for organizing a community response and plan for suicide prevention. This could include community healing and wellness circles.

In the medium term, it is recommended that:

- Health Canada, in partnerships with First Nations, establish demonstration projects, using a formal community development methodology, to engage communities for the purpose of developing interventions that utilize the community's existing abilities, resources and strengths to help youth at risk and that facilitators skilled in these approaches be used to guide the process.

- If no one from the community is qualified, an outside facilitator should be engaged to introduce and mediate the process and prepare and equip local persons to carry on subsequent processes. Facilitators should have knowledge of First Nations history, cultures, communities and tensions between effects of past oppressive forces and conditions necessary for self-determination. They should go through an orientation in each community with which they work.

- Health Canada develop and make available a pool of facilitators knowledgeable in First Nations cultures and skilled in formal community development theory, techniques and processes (see Appendix G), who have undergone an orientation by the community in which they will work. These facilitators can promote/implement the community engagement process and prepare and equip community members to sustain the engagement process.

- Health Canada provide participating communities with funds to cover the costs of the community engagement process. The parameters for setting up pilot projects should give special consideration to the ideas of the youth and take into account community and regional differences across the country.

- A national committee with representation from Health Canada and the AFN be created to develop criteria to be used to identify communities for involvement in the projects. That Regional Offices of Health Canada implement the criteria in partnership with First Nations. When applied, the criteria should identify a range of communities with varying characteristics such as:

remoteness and isolation; status of transferred health care; and level of risk for suicides.

- The demonstration projects be supported by an administrative infrastructure that facilitates collaboration between federal and provincial governments (see Appendix H for details).
  The administrative infrastructure should be integrated with structures to support the clinical and research initiatives outlined in Part 1 of this report. For example, the National Committee could develop and disseminate an information package on suicide prevention "best practices", and coordinate funders to support program ideas that emerge from the community development processes.

- Each community have a coordinating committee to take responsibility for sustaining the community engagement process and ensuring specific initiatives are developed, implemented, and evaluated. Membership of the coordinating committee should consist of a cross-section of stakeholder groups: local elders, youth, cultural/traditional practitioners, health care workers, educators, social service workers, and representatives of the provincial government and Health Canada.

Part 4. Identity, Resilience & Culture

Identity

In the transition from childhood to adulthood, people often experience feelings of isolation and alienation as they attempt to define themselves in relation to the world around them. For many First Nations youth, however, these feelings are particularly intense, the result of continuing racism embedded within the systems of non-Aboriginal society, and dislocation from traditional knowledge and practices. This dilemma was emphasized by RCAP Commissioners who stated that during the course of their deliberations, Aboriginal youth described to them:

> both exclusion from the dominant society and alienation from the now idealized but once-real "life on the land" that is stereotypically associated with aboriginality. The terrible emptiness of feeling strung between two cultures and psychologically at home in neither . . . [107]

The lack of a stable sense of identity in relation to other groups is a key risk factor for suicidal behaviour among First Nations and other Aboriginal youth[108]. "Sense of identity" can be defined as being conscious of the specific group you are part of, in terms of language, values, beliefs and practices.[109] The RCAP Commissioners have made a valid argument that the "importance of a secure sense of identity cannot, and should not, be downplayed or dismissed."[110]

To foster a strong First Nations youth identity, efforts are required at a number of levels. First, there is a need for interventions which result in more opportunities for young people to become connected with their families, communities and culture. In particular, young people must be given the chance to participate in group activities which are healthy and empowering. Suggested

[107] RCAP, op. cit., Canada 1995.
[108] Canada 1996.
[109] Dorais 1995.
[110] RCAP, op. cit.

activities range from the establishment of youth councils and peer support groups to berry picking, storytelling, salmon harvesting and preservation, and community kitchens.

Also relevant in this regard is Chandler and Lalonde's finding that First Nations communities in British Columbia, which have "taken active steps to preserve and rehabilitate their own cultures, are those in which youth suicide rates are dramatically lower."[111] Accordingly, steps must be taken to promote young people's knowledge of their language and traditions, for example by bringing youth and elders together or by establishing safe zones in urban settings (e.g. within friendship and cultural centres) where traditional practices can be learned and shared. As well, the alienation felt by many First Nations youth when confronted with the mainstream educational system is only likely to be addressed if the cultural component of school curricula, including traditional language training, becomes a central element of these students' learning experience.

Moreover, policy makers must also acknowledge that support for First Nations youth "entails the recognition of their need to be taken seriously as having ideas of their own."[112] In the context of a First Nations youth suicide prevention strategy, this means that young people must be involved in its planning, management and evaluation. Not only would their involvement lead to more relevant and meaningful interventions, but it provides direct evidence that governments are prepared to "walk the walk" as well as "talk the talk" when dealing with issues of disempowerment and marginalization among First Nations youth.

Resilience

As is made clear in a study by the Atlantic Health Promotion Research Centre,[113] "resilience" is not a simple concept, but rather

[111] 1998, op. cit.
[112] Canada 1995.
[113] Atlantic Health Promotion Research Centre, 1999.

involves the complex and dynamic interplay between individual attributes and the broader environment. Resilience can be defined as:

> the capability of individuals and systems to cope successfully in the face of significant adversity or risk. This capability develops and changes over time, and is enhanced by protective factors within the individual/system and the environment, and contributes to the maintenance or enhancement of health.[114]

Resilience plays an important role in shaping people's response to problems in their lives. Individuals lacking in resilience are more likely to have feelings of hopelessness and believe that suicide is the only available option. In order to foster resilience in First Nations youth, attention must be focused on strengthening the protective factors that will allow the young people to meet and overcome the challenges in their lives[115]. As noted earlier, these can include aspects ranging from family connectedness, informal support networks and community cohesiveness, to well-developed problem-solving skills and a sense of personal autonomy.

At the most fundamental level, First Nations parents must have access to the tools and resources necessary to raise healthy, happy children. Many First Nations parents or caregivers lack access to a family support network they can draw upon for advice on child- and adolescent-rearing issues – whether because they live away from family members in urban areas, or because their family members on-reserve are not able to provide healthy parenting advice or support. Thus, emphasis must be placed on providing parents and caregivers with adequate parenting support, including information on how to recognize danger signs of suicidal thoughts or behaviour.

In addition to promoting a sense of connectedness among First Nations youth, there is also a need to ensure that community

[114] Reid, Stewart, Mangham and McGrath, ibid., 1999.

[115] Ibid.

resources are in place when friends or family members are not available. For example, young people would benefit from the establishment of a telephone hot-line or e-mail service which they could use to obtain advice and support. There is also a need to develop systems of support for youth who may not have ready access to a telephone or computer.

Similarly, there is a need for services and tools to support First Nations youth who are deemed to be at high risk of suicidal behaviour. As emphasized earlier, young people who abuse substances require age-appropriate counselling and guidance. Comprehensive health services, including mental health services and cultural/traditional practices, must be made available to those who need them.

Also important are measures that engage First Nations youth and give them a reason to be forward-looking in their outlook. This can entail providing young people with opportunities to develop their problem-solving skills, for example by involving them in recreational or league sports. There is also a pressing need for expanded vocational training in First Nations communities, and for economic development activities that enhance job prospects for First Nations youth.

Moreover, in implementing these initiatives, not only must policy makers seek to encourage young people to support one another in pursuing healthy lifestyles and strengthening family relations, but they must also pay attention to structural issues of power, such as unresolved land claims, poverty and substandard infrastructure, which may impact on both the resiliency of individual youth and also of communities.

Culture

First Nations youth live in increasingly diverse and complex communities; still most of them hold language, land and legacy as integral to culture. For them, culture is made up of strengths they want to work on and to add to their past accomplishments and future prospects. In their seminal research, Chandler and Lalonde (1998) show that the concept of cultural continuity provides First Nations youth with a hedge against suicide because it sustains a sense of self and a will to live, especially in times of dramatic change.

The cautionary note here is not to erase the memories of First Nations youth or to sanitize the harsh realities they struggle with. Before forward-looking strategies for suicide prevention can be advanced, it is critical for them to reflect on who they are and where they have come from. On the former, a youth delegate at a conference stated: "Any kid is trying to find him or herself as an individual, but for Native youth there is the additional identity crisis of finding out who they are as a Native person."[116] On the latter, history has determined power relations for youth. To quote: "The loss of land, culture and language is an important factor in suicide. Native youth recognize that they have lost their country and their voice as a people."[117]

With regards to language, First Nations youth have taken up traditional and modern legends, stories and songs, making them feel more competent and useful as a result. By the same token, ceremonies have given them a sense of belonging and have helped to transform their lives. Meanwhile, youth have helped one another to achieve and reinforce these ends and they have used them to come to terms with unmet needs and the problem of suicide. In the report called Choosing Life (1995), the Royal Commission on Aboriginal Peoples (RCAP) underlined the importance of revitalizing or creating appropriate rituals like condolence ceremonies and spirit dances to counter the isolation of individuals and families and to afford them spaces to express their losses and grief. Similarly, mainstream institutions like schools, colleges and universities involve First Nations youth in ceremonies like graduation and awards events even though high drop out rates mark them.

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[116] Discussion Notes from the Suicide Prevention Workshop, 1994

[117] ibid.

Land is healing for First Nations youth who yield to it as a sense of place, a familiar landscape and an educational experience. First, land is a place or territory where family members reside and foster their unique cultures and livelihoods. Second, land is steeped in values and in a landscape made familiar by shared stories: "There was always trust (in the traditional way of life) and it did not get lost. My dad tells me of trapping with my mishomis (grandfather). They would be out on the trapline for days in really bad weather and life-threatening situations, and my dad would trust whatever he would say and trust him completely"[118]. Third, land represents educational experiences in country settings for First Nations youth who often participate in nation-gathering events, back-to-the-land rituals and survival training activities where they learn skills like responsible living, problem solving, team building and other traditional teachings, which may prevent suicide.

As for legacy, First Nations youth are at high risk for suicide if they lack the roots and relationships healthy families and communities afford. To begin, it is important to examine this problem against the backdrop of the positive influence of culture:

> There is clear evidence in research and in Aboriginal experience that a clear and positive sense of cultural identity in institutions that allow for collective self-control, along with strong bonds of love and mutual support in family and community, can act as a protective force against despair, self-destructiveness and suicide[119]

[118] Discussion Notes from the Suicide Prevention Workshop, 1994
[119] Choosing Life, 1995

In theory, family and community roots need to be renewed and reconciled on an ongoing basis to ward off negative intergenerational impacts and tensions that may lead to youth suicide. Notwithstanding widely known problems such as the effects of the trauma of residential schools, isolated incidents can cause grief for First Nations youth as well. Some suffer oppression along cultural lines when individuals and institutions charged with looking after their emotional, physical, mental and spiritual well-being fail in their duties. For example, adoption poses special risks for them especially when family and community members label them as cultural outsiders, a situation which is made worse because they see little recourse for remedial action.

It is important to raise the legacy of residential schools and how this has affected the youth of today. Murray Sinclair (1998) writes about how the detrimental effects of residential schools have lasted over generations:

> For the most part, the children who were removed from their families and sent to residential schools suffered emotional and psychological harm that had differing degrees of impact upon their own coping and parenting skills. Often, the result was a belief on their part that what was "Indian" was bad – their languages, their ceremonies, their beliefs, their rituals, their religion, their Elders and other traditional people. When these children became adults, they sometimes carried on the culturally destructive attitudes and attacks of missionary people with whom they had grown up…None had received instruction in how to raise children. So that when they had families they experienced coping problems [120]

In practice, First Nations youth long for better relationships with their parents. They want their parents to nurture and support them and to protect them against the vagaries of life. A case in point is the young men who are at highest risk to commit suicide. The fear, hurt, shame and anger youth sometimes feel is aided and abetted by parents who neglect and abuse them usually while under the influence of substances like alcohol. In the publication Stories From Our Youth, frank testimonials by youth attest to this:

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[120] Sinclair 1998, p.171

> Sometimes my mom wants to move away from my dad because my dad always beats up my mom. But sometimes my mom gets drunk and she tells me she doesn't love me and it really, really hurts my feeling and it makes me cry.[121]
>
> Many people in our community say that alcohol and other addictions are causing very serious problems…it affected me because my mom drank when she had me.[122]
>
> I think alcohol, drugs and gambling are making problems. You might lose your family, kids, mom and dad because of alcohol, drugs and gambling…Your kids might do the same thing as you are doing. You might kill someone when you are doing drugs and alcohol.[123]
>
> Kids around my age like to swear for nothing. Instead of saying shut-up, they like to use the F-word, B-word or the A-word. They use those swear words because they heard it from their parents…Many people who don't drink show violence and abuse to those they love.[124]
>
> When you were a child, did your mom and dad spend time with you? Did they feed you well, did they tell you tons of evening stories? Did they show you how to do work, did they take you out on the land, did they make you beaded clothes, did they protect you? Did they show

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[121] Stories from Our Youth, 1999:24
[122] Ibid.,27
[123] Ibid., 34
[124] Ibid., 45

> you how much they care, did they show you respect and love? Well, I guess my parents don't do that anymore because they love to drink more than they love me.[125]

In sum, culture is vital to preventing suicides among First Nations youth. Culture has its purveyors and protagonists so parents and peers need attention when youth's reflections and perspectives about suicidal behaviour and suicide are considered. Since language, land and legacy lie at the heart of culture for First Nations youth, provisions need to be made to connect them to these at an everyday level.

Spirituality

Recent years have seen important movements within and across First Nations communities aimed at strengthening and transmitting traditional spiritual knowledge, values and traditions. The term "spirituality" encompasses different traditions and is compatible with different religious affiliations. Common to most First Nations conceptions of spirituality are a sense of connectedness and balance with all of Creation.

Spirituality has been recognized by many as a key part of whole person wellness — encompassing body, mind, spirit and feeling. For First Nations peoples, spirituality has been closely linked to living with the land.

> "The Innu – like many other Aboriginal peoples – believe that the universe is alive with potent spiritual forces which profoundly affect their lives. Recognising their power is as essential for survival as understanding the weather or the changing seasons."[126]

> "What is invisible is our connection to our ancestry, our kinship and alliances, the values we express in our

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[125] Ibid., 53

[126] Samson, Wilson & Massower, 1999

> language, the emotions we feel when living in harmony with nature, our sense of place and peace in the cosmos, our sense of responsibility in honouring Mother Earth, and our heredity."[127]

> "These invisible forces are taught and reinforced through example, by living with and near knowledgeable Elders, through spiritual guides, and through respected leaders. When any of these ingredients are absent or weak in a community, all of its members suffer.[128]

Spirituality offers a clear sense of belonging and purpose and a feeling of acceptance and being understood that allows a person to make choices that show self-respect and respect of others because of a strong individual and collective sense of self.

> "Our ancestors were guided by strong spiritual beliefs and socio-cultural values which gave meaning and structure to all familial and societal relations."[129]

> "In our tradition, the older generation teaches the younger generation about customs and rituals. They are strengthened through daily use, and they set the standards for how we interact, where we live, how we communicate, and how we behave."[130]

Spiritual inter-relatedness with Creation is kept strong through cultural belief systems and practices. The cultural spiritual belief system works from and with whole person wellness. When one aspect or energy of the person is not in balance, the cause is treated to regain balance—balance of the whole person as well as

[127] Focus Group on Suicide Prevention, Executive Summaries, June 1995, Stan Wilson & Peggy Wilson.
[128] Focus Group on Suicide Prevention, Executive Summaries, June 1995, Stan Wilson & Peggy Wilson.
[129] Health Canada 1994
[130] Focus Group on Suicide Prevention, Executive Summaries, June 1995, Stan Wilson & Peggy Wilson.

balance within Creation. Spirituality, therefore, is an important partner in the prevention of suicide.

> "Where traditional societies are still able to operate with their own value system, they can also maintain positive physical, mental, spiritual and emotional health. Life is in balance, and there is order, harmony and control. … Most striking is the emptiness found in our youth at risk, which is often masked temporarily by another culture or spirituality. … That is why the values which guided our ancestors must be restored and honoured in our communities. Without them we will continue to witness adolescent suicide as the most painful expressions of our loss of tradition, culture and belief in ourselves."(13)

Summary and Objectives

This Advisory Group suggests the following objectives for strengthening identity, resilience and culture in a comprehensive First Nations youth suicide prevention strategy:

- Provide youth with opportunities and settings to reflect on the findings of this report and positive mental, emotional, spiritual and physical health and pathways to a positive future, and to share their perspectives on suggested suicide prevention strategies.

- Augment the available sources of support for youth including parents, peers, role models and elders.

- Build on positive alternatives to substance abuse and more positive parenting practices.

(13) Health Canada, 1994.

Recommendations

In the short term, it is recommended that:

- The Youth Council at AFN, along with Health Canada and the AFN Health Secretariat, convene a Roundtable to reflect on the recommendations in this report, respond to the ones that are most meaningful to the youth and recommend the best mechanism(s) for implementing these.

- Health Canada and AFN establish a networking committee with a mandate to promote the roles and responsibilities of youth as peer counsellors, natural healers, and role models for one another. This should be done in conjunction with a media program to promote positive images of youth in a multimedia campaign.

- Health Canada and AFN seek funds through available initiatives to determine best practice models for supporting parenting and family wellness in First Nations communities.

- Health Canada and AFN work with IAPH and NAHO to support the development of projects aimed at enhancing youth's resilience, identity and culture.

Section 4

Concluding Remarks

First Nations are seeking ways to harness public interest, government assistance, the biomedical model of health professionals and scientific and technological interventions, blending these with their own internal strategies, approaches to healing, and resources for preventing suicide. First Nations need support from all of these sources to restore their own health and healing concepts and capacities; to re-engage the active involvement of youth; and to re-organize the complex system of existing programs and emerging policies.

Individuals and organizations involved in programs and interventions at every level must be accountable to communities and to each other (through monitoring and evaluation to ensure provision of quality services). Programs and interventions need to be sustainable and responsive to community needs and best thinking, with appropriate follow through.

Suicide is understood as a problem that does not just affect youth but the whole community. The strength and resilience of youth, families and communities need to be recognized and mobilized. Solutions must involve all members, including children, youth, women and elders. To that end, we offer the following guiding principles for future work on suicide prevention in First Nations communities:

- Engage Community Members
  The collective historical experience of First Nations has included objectification and the imposition of externally developed systems. "Citizen engagement" is about restoring meaningful relations between citizens and their governments by engaging citizens, including youth, to direct fundamental

changes by developing policy, clarifying values and shaping the outcomes of priority issues, such as youth suicide.

- **Ensure Cultural Continuity**
  "Cultural continuity" has to do with the transmission of knowledge, values and identity from one generation to the next. Where this transmission is conducted with a sense of individual and collective health and wellness, belief in an optimistic future, and ability to make decisions today for tomorrow, there will be cultural continuity. Culture and community are not static entities but constantly evolving and changing in response to changing social realities. As such, continuity does not mean simply maintaining the past or repeating actions prescribed by tradition, but re-creating and re-inventing communal practices in ways that maintain connections, honour the past, and incorporate a sense of shared history.

- **Build Capacity**
  Capacity-building improves the knowledge and skills of communities so they can solve problems and perform health functions on their own[132]. Capacity building can include ensuring that youth develop skills required for "learning how to learn" (e.g. literacy) and to resolve issues as well as building other skills.
  To find and implement solutions to the issue of suicide, First Nations must be involved in leading the shaping of research, the building of capacity, the providing of cultural continuity and the channelling of human and material resources for integrated services. It is important that the planning process, and its intended outcomes, be guided by teachings of the past, shared perceptions of present realities, and aspirations for the future and be steered by pertinent principles and values.

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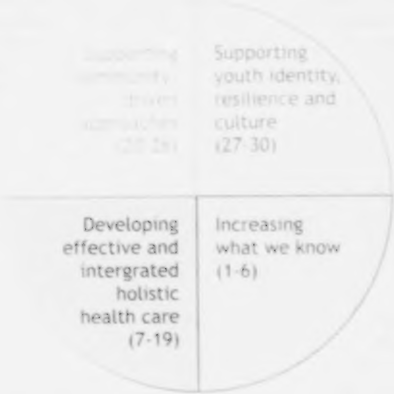
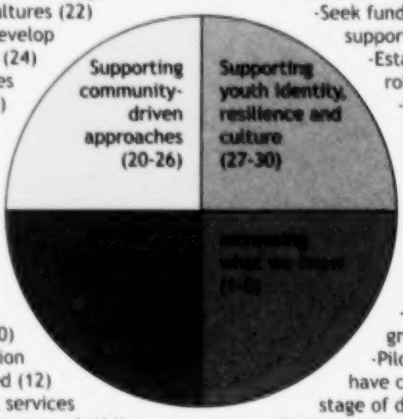
[132] Source: Pauline O'Connor, CPRN Mapping Social Cohesion Discussion Paper No. F/-1, April 1998.

The diagram on the next page illustrates how the key areas of concern identified in this report translate into the recommended actions. The diagram uses the scheme of the medicine wheel to present the four main themes of our recommendations: (1) enhancing and applying what we know; (2) reorganizing mental health care delivery locally and nationally; (3) supporting community approaches; and (4) strengthening the individual and cultural identity of youth as well as other components of resiliency. These actions represent first steps in a process that must be sustained to lead to real change.


Supporting community-driven approaches (20-26)
Supporting youth identity, resilience and culture (27-30)
Developing effective and intergrated holistic health care (7-19)
Increasing what we know (1-6)

First Nations Youth Suicide Prevention
Key Concerns and Recommendations


Supporting community-driven approaches (20-26)
Supporting youth identity, resilience and culture (27-30)
Increasing what we know (1-6)

-Each community to have coordinating committee (26)
-Fund community engagement process (23)
-Demonstration projects be supported to facilitate the collaboration between federal and provincial government (25)
-Develop a pool of facilitators knowledgeable in FN cultures (22)
-Creating national committee to develop criteria to identify communities (24)
-Make guidelines and links to resources available to communities (20)
-Establish demonstration projects to engage communities (21)

-Convene a youth Roundtable to reflect on recommendations (27)
-Seek funds to determine best practice models for supporting parenting and family wellness (29)
-Establish networking committee to promote roles of youth as peer counsellors (28)
-Support development of projects aimed at youth resilience, identity and culture (30)

-Place a high priority on research (1)
-Ensure programs contain an evaluation component (2)
-National conference on suicide prevention (5)
-New national coordinating group for research (4)
-Pilot studies/demonstration projects have clear objectives and plan for next stage of development (3)
-National clearinghouse and website on best practice models (6)

-Increase NIHB funding (8)
-Review and evaluate NIHB mandate (7)
-Development of educational materials (10)
-Current funding allocation methods be altered (12)
-Training to support integrated client services and collaborative interdisciplinary teamwork (14)
-Creation of national FN mental health strategy (11)
-Remunerate professionals on a per-diem basis (15)
-Optimize health resources to communities in crisis (17)
-Design and implement a national crisis consultation services (16)
-Review and evaluate psychotropic medication utilization patterns (13)
-Create and manage a national resource bank of practitioners (18)
-National resource bank to develop a plan to support community workers (19)
-Undertake demonstration project of the 'Community Crisis Assessment Guideline' (9)

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Appendix A

Suicide prevention advisory group

MEMBER PROFILES

Dr. Peter Hettinga

Dr. Hettinga of Longbow Lake, Ontario is the Acting Manager of Mental Health Services at the First Nations and Inuit Health Branch of Health Canada for the Manitoba Region. He served as the Assessment Team Leader for the Youth Forum on Suicide for the Nishnawbe-Aski Nation and has worked as a mental health therapist and crisis intervenor in many First Nations communities. Dr. Hettinga holds a PhD in clinical social work and educational psychology from the University of Minnesota, and an MSW, with a clinical specialization, from the University of Calgary.

Dr. Laurence Kirmayer

Laurence J. Kirmayer is Professor and Director, Division of Social and Transcultural Psychiatry, at McGill University, and editor in chief of Transcultural Psychiatry, a quarterly scientific journal. Dr. Kirmayer also directs the Culture and Mental Health Research Unit at the Department of Psychiatry, Sir Mortimer B. Davis-Jewish General Hospital in Montreal, Quebec. His research includes studies on concepts of mental health and illness in Inuit communities, and risk and protective factors for suicide among Inuit youth.

Mr. Clark MacFarlane

Mr. MacFarlane of Schumacher, Ontario is sole proprietor of The Collaborative Consulting Group Incorporated, a firm that helps organizations throughout Northeastern and Northwestern Ontario to develop and sustain programs and organizations that contribute to the well-being of individuals and communities. Before establishing Community Solutions, Mr. MacFarlane was a Senior Health Planner with the Cochrane District Health Council. He was involved in a number of initiatives in mental health reform, addiction programs, children's mental health, and long term care. Mr. MacFarlane holds an MA in political studies from Queen's University, and an MSW from the University of Toronto.

Dr. Harriet MacMillan

Dr. MacMillan is Associate Professor in the departments of Psychiatry and Behavioural Neurosciences and Pediatrics at McMaster University in Hamilton. She also holds associate memberships in McMaster's departments of Clinical Epidemiology and Biostatistics and Psychology. Since 1993, Dr. MacMillan has been Director of the Child Advocacy and Assessment Program for the Child Abuse Service at the Hamilton Health Sciences Corporation. She holds an MD from Queen's University, and fellowships from the Royal College of Physicians in pediatrics and psychiatry.

Mr. Bill Mussell

A member of the Skwah Band at Chilliwack Landing, B.C., Mr. Mussell is well-known as a consultant and researcher in health, education and welfare policy issues concerning Indigenous peoples. His background in social work, counselling and community development has been applied in community restructuring, team building, child welfare, family development, leadership development, program evaluations, and curriculum development of courses in health, education and corrections. Mr. Mussell is President and Chairman of the Native Mental Health Association of Canada, and Manager and Principal Educator of the Sal'i'shan Institute Society, a non-profit training institute dedicated to the design, delivery and evaluation of health, education and welfare programs tailored to meet the needs of Indigenous peoples.

Rev. Doreen South (Rodenkirchen)

Rev. South is a wholistic consultant who provides services that promote wellness for individuals, families and business for healthier communities. Through workshops, public speaking and counselling, Rev. South shares 32 years of training and experience in stress management, coping with change, building healthier relationships, self-esteem, and positive imaging. She has served on District Health Councils, coordinating committees to end violence, been a guest speaker at the Native Social Studies program at Carleton University, and is currently working with the Akwesasne First Nation Traditional Medicine Program. She is also a consultant for Health and Community Social Services and the Elected Council of Chiefs.

Madeleine Dion Stout

Madeleine Dion Stout is a Cree speaker from the Kehewin First Nation in Alberta. She is very involved in Aboriginal health development and sits on several boards and committees serving non-Aboriginal and Aboriginal groups, two of which are the Federal/Provincial/Territorial Committee on Population Health and the Suicide Prevention Advisory Committee. She was a member of the National Forum on Health and was a Special Assistant to the Honourable Monique Bégin, then Minister of Health and Welfare Canada. Madeleine is past Professor in Canadian Studies and the founding Director of the Centre of Aboriginal Education, Research and Culture at Carleton University and is past President of the Aboriginal Nurses Association of Canada. After graduating from the Edmonton General Hospital as a Registered Nurse, she earned a Bachelor's Degree in Nursing, with Distinction from the University of Lethbridge where she has since been awarded a Distinguished Alumni Award. She now holds a Masters Degree in International Affairs from the Norman Paterson School of International Affairs at Carleton University and has partially completed a Masters degree in Public Administration at Queen's University. As co-author and author of several technical papers on Aboriginal health and as a frequent speaker at local, national and international conferences and in her work as a consultant, Madeleine has worked hard to keep Aboriginal perspectives and aspirations central to Aboriginal health and health care, paying particular attention to those that relate to women and children

Dr. Cornelia Wieman

Dr. Wieman is Canada's first female Aboriginal psychiatrist. A member of the Ojibway Nation and originally from the Little Grand Rapids Reserve in Northern Manitoba, Dr. Wieman is a graduate of the McMaster University medical school, where she also completed specialty training in psychiatry. She is Assistant Clinical Professor in the Department of Psychiatry and Behavioural Neurosciences at McMaster, and was recently appointed the Faculty of Science's Native Students Health Sciences Coordinator. Her clinical and academic interests include Aboriginal health and mental health issues, mental health care delivery to underserviced areas and populations, and the residential school survivors/syndrome.

Appendix B

SUICIDE PREVENTION ADVISORY GROUP
TERMS OF REFERENCE
(Amended)

Goal

To make practical, concrete and doable recommendations to the Minister of Health and National Chief to stem the tide of First Nations youth suicides.

Membership

The panel will consist of individuals with expertise in the issue of youth suicide and mental health who shall be appointed jointly by the Assembly of First Nations and the First Nations and Inuit Health Branch of Health Canada.

Duration

The panel should be established by June 26, 2001 and complete their work by September 30, 2001.

Objectives

- To establish a group of experts to review the existing literature on the issue of First Nations youth suicide.
- To develop a specific set of criteria to determine communities currently at high risk and communities that are highly likely to become high risk based on the literature review and the discussions in the communities.
- To outline a specific strategy to assist communities at risk to develop their own response strategy to address the factors leading to suicide.

- To provide the Minister of Health and National Chief with practical and concrete recommendations within eight weeks of the start date. The recommendations should outline short and long term strategies.

Appendix C

List of Documents Reviewed

American Academy of Child and Adolescent Psychiatry. (2001). Practice parameter for the assessment and treatment of children and adolescents with suicidal behaviour. **Journal of the American Academy of Child and Adolescent Psychiatry, 40** (7 Suppl), 24S-51S

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Appendix D

Research on Suicide Prevention and Mental Health Promotion in First Nations Communities**

(Adapted from: Kirmayer, L. J., Boothroyd, L. J., Laliberté, A., & Laronde Simpson, B. (1999). Suicide prevention and mental health promotion in Native communities (No. 9). Montreal: Culture and Mental Health Research Unit, Institute of Community & Family Psychiatry, Sir Mortimer B. Davis—Jewish General Hospital.)

Suicide Prevention/Mental Health Promotion Programs Reviewed

Programs with an asterisk* indicate recommended programs; further information on these programs is detailed below.

- Adolescent Suicide Awareness Program (ASAP)
- Cherish the Children
- Child and Family Resource Centre
- Community-Based Suicide Prevention Program*
- Family Workshops: Parents and Problems*
- Jicarilla Mental Health & Social Services Program*
- Kishawehotesewin: A Native Parenting Approach
- La prévention du suicide auprès des jeunes en milieu scolaire (School-based Suicide Prevention for Youth)
- La prévention du suicide en milieu scolaire secondaire: Une approche communautaire (Community Approach to Suicide Prevention)
- Let's Live*
- Life Skills Education for Children and Adolescents in Schools*
- Mauve CD-ROM*
- Mental Health Education
- Miyupimaatisiiuwin Wellness Curriculum*
- Native Parenting Program*
- Ngwaaganan Gamig Recovery Centre (Rainbow Lodge) and Nadmadwin Mental Health Clinic

- Northwest Territories School Health Program
- Parenting Education Program
- Plein le dos : Programme de prévention du suicide en milieu scolaire primaire (Elementary School Suicide Prevention Program)
- Prévention et promotion du mieux-être (Prevention and Promotion of Well-Being)
- Program to Enhance Self-concept in Young Children
- Programme d'entraide par les pairs (Peer Support Program)*
- Rescousse: Groupe d'entraide (Rescue)
- Seniors Group
- Skills for the Primary School Child (SPSC)
- Sparrow Lake Alliance
- Suicide Prevention Curriculum
- Suicide Prevention Training Programs' Workshop
- Teen Esteem
- Before the Fact (SPIRC)
- Vision Seekers

Recommended Programs*

Jicarilla Mental Health and Social Services Program

This program uses a community-based, family-centred approach to suicide prevention, and emphasizes cultural values and traditions. It focuses on specific risk factors for suicide (alcohol and substance abuse, physical, sexual, and emotional abuse and neglect of children) and addresses community problems through education on domestic violence, child abuse, economics, sexuality, substance abuse, and parenting.

The Jicarilla Mental Health & Social Services program is part of the American Indian/Alaska Native Community Suicide Prevention Center & Network (AI/AN CSPCN). The focus of the network is to develop suicide prevention and intervention programs, crisis response teams, and information sharing between Native communities.

For more information:
Pat Serna, Director
Jicarilla Mental Health & Social Services
P.O. Box 546
Dulce, New Mexico 87528
(505) 759-3162 (telephone)
(505) 759-3588 (fax)
cspcn@cvn.com (e-mail)

Community-Based Suicide Prevention Program

The Community-Based Suicide Prevention Program (CBSPP) has been developed and implemented by Alaska Native communities. The CBSPP program is state-funded and provides grants to support community-based suicide prevention activities. These activities target different areas of the prevention spectrum, ranging from mental health promotion to suicide intervention and postvention. Many of the projects supported by CBSPP focus on traditional activities that promote cultural values such as elder and youth exchanges, where the elders share their knowledge and wisdom with the younger generation. These exchanges enhance the elders' self-esteem and teach respect to the youth, as they create a favorable climate to pass on important cultural knowledge.

For more information:
Susan Soule, Community-Based Suicide Prevention Program
Rural Services, Division of Alcoholism & Drug Abuse
Alaska Department of Health & Social Services
Box 110607
Juneau, Alaska 99811-0607
(907) 465-3370 (telephone)
(907) 465-2185 (fax)

www.hss.state.ak.us/htmlstuf/alcohol/SUICIDE/SUICIDE.HTM
(website)

Miyupimaatisiiuwin Wellness Curriculum

The Miyupimaatisiiuwin Wellness Curriculum presents a comprehensive school-based approach to health promotion and, by extension, to long-term suicide prevention. The Miyupimaatisiiuwin Wellness Curriculum is comprehensive, covering a wide range of "wellness" issues in a practical, teacher-friendly format, including ready-to-use lessons and preparatory material. It is a preventive program with an emphasis on wellness through health promotion for kindergarten to grade 8.

The focus is on "wellness," considered by the development team to be an alternative perspective based on issues of self-esteem, positive self-concept development, awareness of peer pressure, values, and abuse prevention. The development team considers these factors to be contributors to the prevention of suicidal behaviours, although there is no specific suicide-related theme in the curriculum.

For more information:
Barbara Reney
SWEN Productions
3622 rue De Bullion #2
Montreal, QC H2X 3A3
(514) 849-8478 (telephone)
(514) 849-2580 (fax)

Let's Live! ASK•ASSESS•ACT

Let's Live! is an example of a school-based awareness and intervention program that meets some of the RCAP (1995) general guidelines for suicide prevention approaches. The program guide covers the inservice workshop and provides the content and procedures for two sessions. Resources and materials, including handouts and a teacher's manual, are followed by theme-based lessons for students, covering the following topics: What is Suicide?; How Can I Tell if Someone is Suicidal?; Why Do Teenagers Attempt Suicide?; How Can I Help Someone Who is Suicidal?; and How Can I Get the Most Out of My Life?

A one-day workshop on suicide intervention for school personnel (gatekeepers) was developed to replace the in-service training component of the Let's Live! program. The workshop was given a new name— ASK▪ASSESS▪ACT—to distinguish it from the student component of Let's Live! and to better reflect training goals. Its aim is to improve the overall competency of school personnel in the recognition and crisis management of potentially suicidal youth.

For more information:
Cheryl Haw, Director
B.C. Council for Families
204-2590 Granville Street
Vancouver, BC V6H 3H1
(604) 660-0675 (telephone)
(604) 732-4813 (fax)
bccf@istar.ca (email)
www.bccf.bc.ca (website)

Life Skills Training

The World Health Organization (WHO) has developed a life skills education program for children and adolescents. The goals of a life skills program are to teach skills that individuals need in order to deal effectively with the demands and challenges of everyday life, such as communication, decision-making, self-awareness, and problem-solving skills.

For more information:
Dr. J. Orley, Senior Medical Officer
Division of Mental Health
World Health Organization
1211 Geneva 27
Switzerland
(011-41) 22-791-4160 (fax)

Programme d'entraide par les pairs (Peer Support Program)

This is a prevention and intervention program aimed at youth in secondary school. The program promotes personal growth, better communication skills, and the support of friends in need. It helps peers to be better listeners, encourages help-seeking from professionals, and raises awareness of the signs of suicidal thoughts. The philosophy behind the program is the implementation (and sustaining) of a support network as a concrete, "community" approach to reducing distress.

For more information:
Joyce Chagnon
Fondation JEVI
86 13e avenue Nord
Sherbrooke, QC J1E 2X7
(819) 564-1354 (telephone)
(819) 564-4486 (fax)

Native Parenting Program

This is a 12-week course, run twice a year for 15-20 participants, that starts with the Nobody's Perfect parenting program (combined with the Native Kisewatotatowin Parenting Classes) and is followed by a Native Cultural Program. Most of the participants are of Aboriginal ancestry. The goals of the Native Parenting Program are to engage people in speaking about their own experiences, help participants gain a deeper understanding of their emotions and anger, examine Native customs and parenting skills, increase cultural pride and self-esteem, promote recognition of risk factors, and increase knowledge of the resources available and how to access them.

For more information:
Louise McKinney, Native Health Worker and Parent Educator
Westside Community Clinic
631 20th Street West
Saskatoon, SK S7M 0X8
(306) 664-4310 (telephone)
(306) 934-2506 (fax)

Family Workshop: Parents and Problems Parenting Program

The Family Workshop: Parents and Problems Parenting Program, developed in the U.S., has been implemented in the First Nation community of Big Cove, New Brunswick. The goals of the program are to enable parents to better understand their own behaviour towards each other and their adolescent(s), how adolescents perceive the behaviour of their parents, and what makes adolescents behave as they do. In this way, the program aims to prevent mental health problems, drug and alcohol abuse, and criminal activity among adolescents.

For more information:
Harry Sock, Director
Child and Family Services
Big Cove Indian Band, Site 11, Box 1
Big Cove, NB E0A 2L0

Multimedia CD-ROM: Mauve

Mauve CD-ROM was produced by Médiaspaul and Pentafolio Inc., with the participation of Health Canada, for young people aged 12-18 years. This interactive tool, available in English or French, aims to help foster independent thinking and encourage dialogue. The goals are to help teenagers with problems open up, reduce feelings of isolation by presenting viewpoints from teenagers facing similar difficulties, and help youth identify self-destructive patterns, view problems more objectively, and gain a sense of life's deeper meaning. In this way, the tool aims to promote positive attitudes regarding the topics covered (e.g. love, sex, work, school, family, society, life and self-image), create general health awareness, promote mental health and prevent depression, drug abuse and suicide.

For more information:
Médiaspaul Inc.
3965 boul. Henri-Bourassa Est
Montréal-Nord, QC H1H 1L1
(514) 322-7341 (telephone)
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Suicide Prevention Information and Resource Centre (SPIRC)

The primary role of SPIRC was to advance and support the BC Ministry for Children and Families' (MCF) provincial youth suicide prevention strategy. The Centre was a part of the Mental Health Evaluation & Community Consultation Unit (MHECCU), in the Department of Psychiatry at the University of British Columbia.

SPIRC sought to provide support, guidance and consultation to the MCF regions to facilitate planning in youth suicide prevention. SPIRC worked closely with the MCF regions to ensure that their 3-year plans include comprehensive strategies for preventing youth suicide and suicidal behavior, reflecting concepts outlined in provincial planning and support documents.

In order to meet the above stated objectives, SPIRC engaged in activities in the following three areas: community support, education and skill development and information collection and dissemination.

In 1998, SPIRC published "Before the Fact Interventions: A Manual of Best Practices in Youth Suicide Prevention". The manual identifies fifteen approaches to working with individuals, families, schools and communities to reduce the risk of youth suicide. The suicide prevention strategies are intended to be "before the fact", targeting communities healthy populations, groups at early risk stages, or groups where a specific risk for suicide has not yet been identified.

For more information or to obtain a copy of the "Before the Fact" Manual:
Mental Health Evaluation & Community Consultation Unit

Department of Psychiatry, UBC
2250 Wesbrook Mall
Vancouver, British Columbia
Canada, V6T 1W6
(604) 822-1736 (phone)
(604) 822-7786 (fax)
www.mheccu.ubc.ca

*While some of these programs are no longer in existence, they provide solid frameworks to base new programs on. General information for most programs can be obtained by contacting the program directly or from the Culture and Mental Health Research Unit in Montreal. Information on additional suicide prevention programs may be obtained by contacting the Suicide Information & Education Centre at:

Suicide Information & Education Centre (SIEC)
201-1615-10th Avenue. SW
Calgary, Alberta CANADA T3C 0J7
Phone: 403-245-3900
Fax: 403-245-0299
Email: siec@suicideinfo.ca
Web: www.suicideinfo.ca

SIEC is a program of the Canadian Mental Health Association, Alberta Division.

They have produced a handbook:
Jennifer White and Nadine Jodoin "Aboriginal Youth: A Manual of Promising Suicide Prevention Strategies"at the Suicide Prevention Training Programs, Calgary, AB

Contact info:
sptp@suicideinfo.ca

Appendix E

An Analysis of NIHB-Funded Mental Health Services: Implications for First Nations Youth Suicide

Cornelia Wieman, M.D., FRCPC
Six Nations Mental Health Services, Ohsweken, ON & Dept. of Psychiatry, McMaster University, Hamilton, ON

This paper provides further detail in relation to Section 3 Part 2 of the preceding report.

What is the Non-Insured Health Benefits Program?

- NIHB is but one program of the First Nations and Inuit Health Branch of Health Canada
- The NIHB Program provides a range of medically necessary goods and services which are intended to supplement benefits provided through other private or provincial / territorial programs
- The purpose of the NIHB Program is to provide health services in a manner that: "1) is appropriate to [our] unique health needs; 2) contributes to the achievement of an overall health status for First Nations and Inuit people that is comparable to that of the Canadian population as a whole; 3) is sustainable from a fiscal and benefit management perspective; and 4) facilitates First Nations and Inuit control at a time and pace of [our] choosing".[1]
- Benefits under the NIHB Program include: pharmacy (including prescription and over-the-counter medications, medical supplies and equipment), dental care, vision care, transportation to access medical services, health care premiums in Alberta and British Columbia only, and other

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[1] Non-Insured Health Benefits Program 1999/2000 Annual Report, First Nations and Inuit Health Branch, p.3

health care services including crisis intervention mental health counselling[2]

- NIHB Program funding is intended to "provide limited funding of last resort for professional mental health treatment for individuals and communities in at-risk, crisis situations[3]

- To maintain quality of care and accountability of service, NIHB-funded mental health services are provided by mental health professionals including those in the disciplines of psychology, psychiatric nursing and social work[4]

Who Receives Non-Insured Health Benefits?

- The total number of eligible clients is 690,151 as of March 2000[5]

- The highest numbers of eligible clients are in Ontario (151,741) followed by the Pacific Region (109,847) and Manitoba (104,821); these regions represent 22%, 15.9% and 15.2% of the national total respectively

- Of the total number of eligible clients, 95% are First Nations and 5% are Inuit

- Between 1990/91 and 1999/00, the First Nations and Inuit population has grown at an average annual rate of 2.9% compared to 1.2% for the general Canadian population, making it the fastest-growing segment of the Canadian population

- Between 1989/90 and March 2000, the number of eligible clients on the Status Verification System (SVS) has increased by over 32%

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[2] NIHB 1999/2000 Annual Report, p.3

[3] NIHB Interim Program Directive, No. 7, Mental Health Services, Preamble, p.1

[4] NIHB Interim Program Directive, p.1

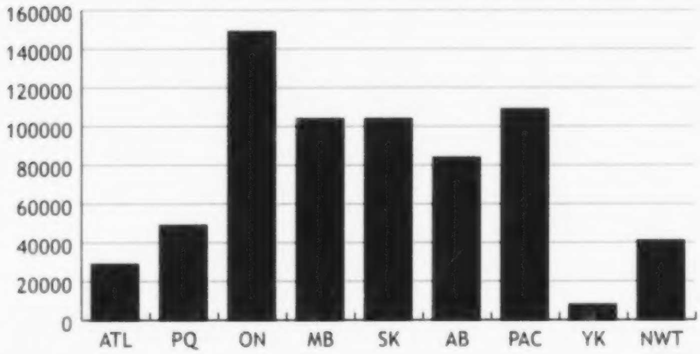
[5] all data in this section from NIHB 1999/2000 Annual Report pp. 5-12

- Nationally, the number of First Nations clients increased by 2.7 % between 1999 and 2000 with Manitoba having the largest increase in clients by region (3.5 %)

- Of all eligible clients on the SVS, 51% are female and 49 % are male

- Almost all of the First Nations and Inuit population is under 40 years of age; the average age of the eligible client population is 28 years

Eligible Client Population By Region (March 2000)



What are the NIHB Program Expenditures?[6]

- For 2000/01, the total budget for the Indian and Inuit Health Programs Envelope is set at $1.2 billion; of this, $613.8 million is for Health Services (~51 % total); $28.9 million is for Hospital Services (~2 % total) and $570 million is for NIHB (47 % total)

- Over an eight year period (1988 - 1996), expenditures for the NIHB Program have grown from ~$214 million to over $500 million; however, the rate of growth in expenditures has decreased from 22.9 % in 1990/91 to 5.7 % in 1999/00

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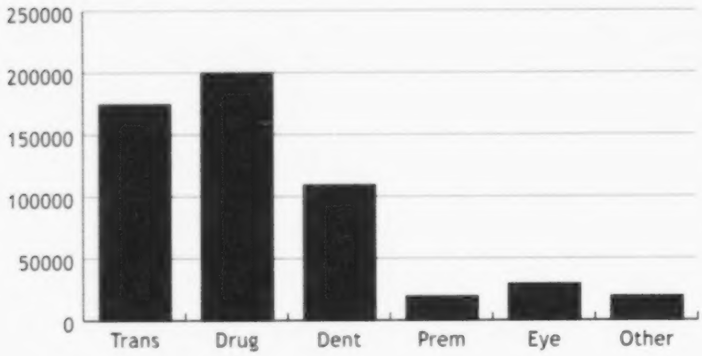
[6] all data in this section from NIHB 1999/2000 Annual Report pp. 17-58 unless otherwise noted

- In 1999/00, NIHB expenditures were ~$545 million, a 5.7 % increase from ~$516 million in 1998/99; these increased expenditures reflecting increases in the numbers of eligible clients and in benefit costs and changes to provincial health care systems

- The breakdown of NIHB expenditures in 1999/00 by benefit is as follows:

NIHB Annual Expenditures by Benefit - 1999/00 ($ 000's)



In this chart, 'other' represents other health care services, which include mental health services. In 1999/00, ~$16.1 million was spent on other health care services (3 % of total NIHB budget of ~$ 545 million). Between 1991/92 and 1999/00, other health care costs decreased by 56 %. These figures do not include monies allocated for various contribution agreements.

- Pharmacy benefits (~$ 206.9 million) were the largest NIHB expenditure for 1999/00 while the 'other health care' category which includes mental health services accounted for only 3 % of the NIHB annual expenditures (~$ 16.1 million)

- Between 1998/99 and 1999/00, 'other health care' which includes mental health services was the only benefit showing a decrease in expenditures (-19.1 % change)

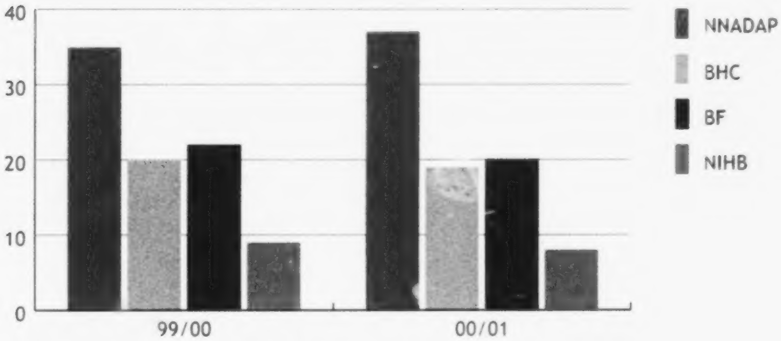
- In 1999/00, Ontario accounted for the largest proportion of total expenditures at $ 104.7 million (19.2 % of total) followed by Manitoba at $ 92 million (~17 % of total)

- Over a 10-year period from 1990 – 2000, total NIHB expenditures have increased at a faster rate in the Manitoba Region (125 %) compared to Ontario (88 %)

What are the NIHB-Funded Mental Health Expenditures?

- Mental health services for First Nations peoples are provided by a variety of programs including Building Healthy Communities (BHC) and the National Native Alcohol & Drug Abuse Program (NNADAP) as well as through NIHB.

Mental Health Expenditures -Various Programs
1999/00 - 2000/01



In 2000/01, NNADAP = ~$ 37.7 million; BHC = ~$ 19.2 million; BF= ~$ 20.1 million and NIHB mental health counselling = ~$ 8.4 million. These expenditures total ~$ 85.5 million.

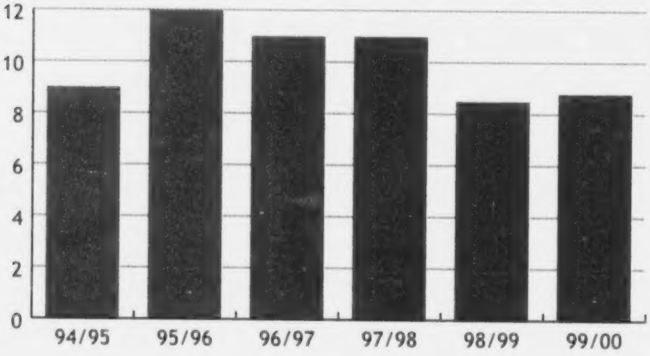
- Mental health counselling is included in the NIHB 'other health care' category and accounts for ~50 % of the $ 16.1 million budgeted in 1999/00 (~$ 8.9 million)

- Between 1999/00 and 2000/01, total mental health expenditures from the various programs below were reduced from ~$ 88.1 million to ~$ 85.5 million[7]

- NIHB-funded mental health counselling was reduced from ~$ 8.9 million to ~$ 8.4 million over the same period

- NIHB-funded mental health counselling can be further broken down as follows:[8]

1999/00 ($ million)



While NIHB-funded counselling reached a peak at ~$ 11 million in 1996/97; over the past 2 years, it has remained between ~$ 8.6-8.9 million. These figures do not include other funding sources such as contribution agreements.

- Strategies targeting mental health crisis intervention and funded through Building Healthy Communities have also experienced decreased funding over the years:[9]

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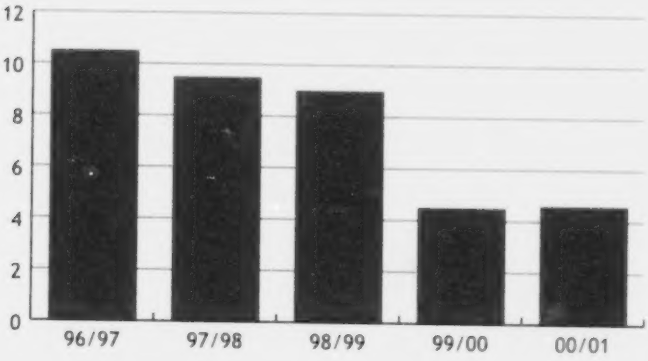
[7] information provided directly by First Nations and Inuit Health Branch, Health Canada, 2001 [8] information provided directly by First Nations and Inuit Health Branch, Health Canada, 2001

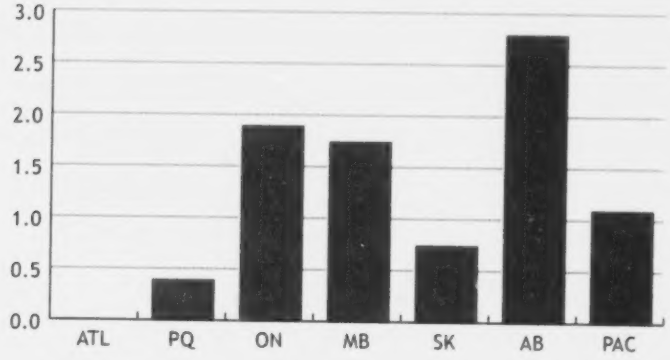
[9] information provided directly by First Nations and Inuit Health Branch, Health Canada, 2001

BHC-Funded Mental Health Crisis Intervention 1996/97 - 2000/01 ($ million)



- Other sources of information regarding NIHB utilization are inconsistently reported across regions; for example, there is no specific information for the year 2000/01 for the Atlantic, Ontario and Nunavut regions in terms of standing offer and contribution agreements as well as fee-for-service data.

NIHB-Funded Counselling by Region - 1999/00 ($ million)



- There are also reporting difficulties in separating data between on- & off-reserve

- In Alberta, ~$ 1.6 million was spent for fee-for-service counselling: ~4000 clients were seen an average of 5 sessions/client which totaled ~$ 400/client

- There is no NIHB utilization data available for specific 'hot spot' communities or communities considered at high-risk for youth suicides at this time

- In 1999/00, of the national top ten prescription drug products by expenditures, 2 are antidepressant medications: Paxil – 20 mg tab ($ 2.64 million spent) and Zoloft 50 mg capsule ($ 1.02 million spent)

What are Some of the NIHB Counselling-Related Issues?[10]

- The number of counselling sessions available per client vary by region and in some cases, there have been decreases imposed on the maximum number of sessions that a client will be funded to receive

- There have been issues raised regarding the timeliness of approval for counselling sessions thereby allowing for the crisis 'to pass' before counselling is initiated

- In some regions, the process of applying for approval of sessions is considered both labor- and paper-intensive

- There are issues around eligibility for services and how one is registered on the SVS

- There are issues related to individuals who live on- or off-reserve in terms of their ability to access services; for example, if NIHB-funded counsellors practice off-reserve, there may be difficulties in travelling to/attending counselling sessions

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[10] these issues were derived from discussion within the Suicide Prevention Advisory Group

- Some clients may feel that the counselling they do receive is not culturally-sensitive or culturally-relevant
- Youth in particular may feel that they are unable to 'relate to' the counsellors available to them thereby affecting their ability to establish a therapeutic alliance and/or to comply with counseling
- Counsellors may vary in their ability to deliver effective, evidence-based mental health services and to advocate for clients with specialized mental health needs
- NIHB-funded counsellors may vary in terms of their perceived comfort/confidence in dealing with difficult patients including those who are acutely suicidal
- Counsellors may be forced out of necessity or urgency to use the counselling sessions in ways that they are not intended (ie. for other than short-term crisis intervention; or in some cases, doubling up on the number of sessions actually funded for)
- Confidentiality is an important concern for individuals considering entering into a counselling relationship and becomes even more critical in smaller communities
- Individuals who have complicated histories and multiple mental health issues (eg. relationship and family difficulties, concurrent substance abuse, domestic violence, criminal history) may be receiving services from multiple agencies which results in a fragmentation and a lack of coordination of their care.

- There is regional variation on how the NIHB directive is interpreted which is related to what services are delivered; for example, the directive implies that funding is available for individual and communities in at-risk, crisis situations.[11]

What can we Conclude from the Data & Subjective Issues?

- Much of the existing 'hard data' is not an accurate representation of the amount and quality of services provided through the NIHB Program and therefore the implications for suicide prevention cannot be definitively inferred.

- There are inter- & intra-regional differences in the utilization of NIHB resources which also makes it difficult to attain a conclusive answer to the question (objective). This variation partly depends on how regions have interpreted the Interim Program Directive (ie. services are directed solely at individuals).

- According to the Interim Program Directive, NIHB funds may be accessed by specific communities in at-risk, crisis situations but it is not known to what extent and with what frequency these resources are utilized for this purpose.

- It is apparent from the numbers that mental health services are not a prominent part of the total NIHB expenditures.

- The subjective data (counselling-related issues) suggests that the current system of NIHB funding used for individual mental health counselling does not function optimally and therefore is unable to achieve its mandate in the most helpful way for individuals and communities in at-risk, crisis situations

What can be Recommended?

- That further effort be focused on determining whether or not specific communities considered to be at high-risk for suicides are accessing currently available NIHB funds for treatment.

[11] NIHB Interim Program Directive, No. 7, Mental Health Services, Preamble, p.1

- That the current committee looking at 'renewal' and the NIHB directives give special consideration to the issue of suicide.

- Health Canada Regional offices should encourage more latitude and a broader interpretation of the NIHB Interim Program Directive for Mental Health Services to allow for greater access to services on-reserve in all regions.

- That existing mental health services offered through NIHB be optimized. The current focus is on tertiary prevention only – the focus could be shifted to include secondary prevention services (ie. early detection and treatment).

- Given that current NIHB expenditures for mental health services have been either maintained around a set level or decreased and knowing that the eligible population continues to increase, that consideration be given to increasing the proportion of funding for mental health services within the NIHB budget.

Appendix F

Community Crisis Assessment Guideline

The following community crisis assessment guideline, referenced in Part 2 of the preceding report, is offered for review, testing and modification. This assessment guideline borrows from the Nishnawbe-Aski Nation Youth Forum on the suicide community assessment process carried out at the beginning of each community forum as directed by the Assessment Team Leader.

This guideline can be used by community mental health workers to assess their community and develop a plan of action to address issues of concern. The community may wish to involve a professional mental health therapist in the process in order to develop a "diagnosis and treatment plan" for the community based on "estimated duration of treatment" (FNIHB Interim Program Directive for Mental Health Services, 1994). The community mental health workers may wish to incorporate such a community based diagnosis and treatment plan as part of their plan of action to deal with community mental health and suicide issues.

It is important to ensure that this assessment is seen as part of a community healing process. Consequently, caution is advised in the use and completion of the assessment guideline, by community mental health workers, so as not to create greater fear and alarm in the community.

COMMUNITY IDENTIFICATION

a) Name of Community:

____

b) Located in FNIHB Region of:

____

c) Total Population Residing "On Reserve":

____

Approximate Distribution by Age:

0 - 6 years: ____	20 - 30 years: ____
7 - 12 years: ____	31 - 50 years: ____
13 - 19 years: ____	Over 50 years: ____

d) This Assessment Guide is being completed by:

Name: ______________________

Position: __________________________

Position within or relationship to the Community:

________________________(List all key informants/participants)

e) FNIHB Facility- Please check the type of FNIHB facility in the community:

Nursing Station: ____ Health Centre: ____ Other: ____

f) Describe the Location of the Community:

____

____

Location of community in relation to hospital, physician(s), and mental health services:

____

Please Check the description the best describes the community:

☐ • non-isolated road access (less than 90 Km. away)

☐ • semi-isolated, road access (greater than 90 Km. away)

☐ • isolated (scheduled flights, telephone service, no road access)

☐ • remote (no scheduled flights, minimal telephone service; no road access)

☐ • other (please explain)

***Please attach explanations on a separate page as needed**

DESCRIPTIVE REVIEW OF THE COMMUNITY

a) Completed suicides in the past two years: (Please complete these questions for each suicide completed in the last two years)

Name (Optional):

____

Age: _____ Sex: _____ Date: ______________________

Circumstances:

- Previous Attempts: Y: __ Number (approx): ____ N: __
- Conflict with boy or girl friend or relationship partner: Y: __ N: __
- Conflict with parent or parent figure: Y: __ N: __
- Was drug or alcohol Abuse involved? Y: __ N: __
- Where did the individual reside?
  Please explain: ____________
  ____
- Method:
  Please explain:
  ____
- Was mental health counselling acquired in community from social/mental health workers or professionals (e.g. CFS, mental health therapist, psychologist, community worker, nurses, or medical doctors): Y: __ N: __
  Please explain:
  ____
- Previous hospitalization for mental health assessment or treatment reasons (when, where):
  Please explain:
  ____
- Circumstances:
  Please explain:
  ____

b) Attempted Suicides in past two years: (Please complete these questions for each suicide attempted in the last two years)

Name (Optional): ______________________

Age: ____ Sex: ____ Date: ______________

- Circumstances:

  Previous Attempts: Y: __ Number (Approx): ____ N: __
- Conflict with boy or girl friend or relationship partner: Y: __ N:__
- Conflict with parent or parent figure: Y: __ N: __
- Was drug or alcohol Abuse involved? Y: __ N: __
- Where does the individual reside?

  Please explain:

  ____
- Method:

  Please explain:

  ____
- Was mental health counselling acquired in community from social/mental health workers or professionals (e.g. CFS, mental health therapist, psychologist, community worker, nurses, or medical doctors)

  Please explain:

  ____
- Previous hospitalization for mental health assessment or treatment reasons (when, where):

  Please explain:

  ____
- Circumstances:

  Please explain:

  ____

c) Please note whether, in your own opinion, the above completed and/or attempted suicides constitute a cluster. Factors to consider are the similarities and connection between completed/ attempted suicides, timing, children in care (in past and present), psycho-social profiles, clinical histories, and previous involvement with social/mental health workers and professionals, relationship problems and any known suicide pact arrangements.

Please provide description and explanation factors:

____

____

____

COMMUNITY COHESION:

a) # of high-risk individuals (e.g. previous attempts as identified by community workers): ____

Please explain:

____

b) # of "children in care", "in community" placements: ____ "out of community" placements: ____ Total: ____

c) Percentage of children being reared by biological parent (one and both), ____% step-parent ____%, relatives (formal or customary) ____%, other First Nation members ____%, or other non First Nation: ____%

d) # of non suicide deaths in the past two years through "non-natural means" by type (i.e. accidental, violence): ____ and the circumstances surrounding each death:

____

e)

1) percentage of youth/children with addiction issues (i.e. sniffers, drug abusers, alcoholics): _____%

2) percentage of adults with addiction issues (i.e. sniffers, drug abusers, alcoholics): _____%

f) # of family units with more than one family member with addiction issues: ____

g) anecdotal accounting by community workers of abuse indicators present (physical, sexual and emotional):

____

h) # of reported sexual assaults in past two years: ____

i) # of reported physical assaults in past two years: ____

j) # of family violence reports in past two years: ____

***Please attach explanations on a separate page as needed**

k) traumatic events that have happened in and to community:

l) loss of respected Elders, leaders or others:

FAMILY INTEGRATION FACTORS:

a) Role of Elders in extended family systems (advisors, counsellors, healers)? Please explain:

b) Interactional patterns (conflict, co-operation) between extended family systems/factions?

Please explain:

c) Familial instability (marital & family break-ups)?

Please explain:

d) Childhood separation and loss?

Please explain:

e) Interpersonal and inter-familial conflict?

Please explain:

IDENTIFICATION OF THE CURRENT STATUS OF THE COMMUNITY HEALING PROCESS

a) Community ownership over "child-in-care" decision-making, involvement in supporting "at-risk" families, role and functioning of family service committee (or equivalent)?

Please explain:

b) Role of community Elders in community decision-making processes?

Please explain:

c) Role of positive adult role models in assisting children/youth "at-risk"?

Please explain:

d) Extent to which the community embraces individual members as belonging to the collective (as opposed to "not belonging")?

Please explain:

e) Extent of customary healing practices within the community based on traditional customary practices?

Please explain:

***Please attach explanations on a separate page as needed**

f) Accepting responsibility for and addressing past sexual or physical abuse at the community level (e.g. healing circles)?

Please explain:

____

____

____

g) Identifying and supporting individuals with friends or relatives that have committed suicide?

Please explain:

____

____

____

REVIEW OF COMMUNITY AND TRIBAL SOCIAL AND MENTAL HEALTH SERVICE DELIVERY

a) Community relationship with the FNIHB:

transferred community: Y: __ N: __

integrated agreement: Y: __ N: __

b) Contribution agreement for Non-Insured Health Benefits (NIHB) funded mental health services: Y: __ N: __

at the community level: Y: __ N: __

at the Tribal Council level: Y: __ N: __

If yes, Name of Agency: ______________________________

c) Mental health therapist contract:

at the community level: Y: __ N: __

at the Tribal Council level: Y: __ N: __

NIHB funded: Y: __ N: __

If yes, name of therapist and company/agency (if applicable):

____

d) Is access to the NIHB funded mental health therapist on a per client fee for service basis: Y: __ N: __

If yes, name of therapist and company (if applicable)

____

e) Brighter Futures Initiative Description:

Funds received: _________________________

Staff hired: ____________________________

Activities:

____

____

____

f) Building Healthy Communities Program Description:

Funds received: _________________________

Staff hired: ____________________________

Activities:

____

____

g) Access to provincial mental health services: Y: __ N: __

Type:

Please explain:

____

____

____

____

h) National Native Alcohol and Drug Abuse Program:

Funds received: _________________________

Staff hired: ____________________________

Activities:

____

____

i) Access to Aboriginal Healing Foundation funded services

Please describe funding, staffing and activities carried out at the community level:

***Please attach explanations on a separate page as needed**

____
____
____
____

j) Describe community recreation facilities or programming:

____
____
____

COMMUNITY SELF HELPING PROCESSES

a) Is there a linkage between suicidal behaviors and youth development processes: response from community workers to youth in crises; youth activities community inclusion and involvement?

Please explain:

____
____
____
____

b) Efficacy of current community worker resources in identifying and monitoring high-risk individuals; level of support proactively provided to high-risk individuals? Please explain:

____
____

c) Worker or volunteer response to suicide attempts/verbalizations/gestures, organization of response strategy, allocation of resources, community education and out reach efforts?

Please explain:

____
____
____
____

***Please attach explanations on a separate page as needed**

d) Frequency of community worker team meetings, effectiveness in identifying and serving high risk clients, case conferencing and management procedures, task assignment and monitoring, remedial mechanisms to improve service delivery? Please explain:

____

____

____

____

e) Community worker team commitment to promoting positive mental health of high-risk individuals by connecting them to community social structure (individual home visits, assertive outreach, facilitating Elder involvement with high risk individuals)?

Please explain:

____

____

____

____

f) Strengths and weaknesses of community health and suicide service delivery system?

Please explain:

____

____

____

____

IDENTIFICATION OF COMMUNITY INFRASTRUCTURE ISSUES

a) # of homeless and "near homeless" (especially adolescents/young adults previously "in -care"): ______

b) Does the community resource team ensure that the work is carried out by its team members?

***Please attach explanations on a separate page as needed**

Please explain:

____

____

c) Are steps being taken to ensure the continuity of culture in the community? (e.g. assisting youth feel connected to their traditional and cultural origins)

Please explain:

____

____

____

d)Existence of cultural facility, traditional customary practices, involvement of youth in community culture; culture as heart beat/drum beat?

Please explain:

____

____

____

e) Community history:

Relocation, amalgamation, forced change of lifestyle, post traumatic stress.

Please explain:

____

____

____

____

f) Does the community have control over finances? (i.e. Is the community in third party management): Y: __ N: __

If Yes, who is the third party manager?

____

REVIEW OF SELF-CONTINUITY FACTORS:

a) Does the community have the ability to maintain and support a sense of self-continuity by adolescents? (e.g. help youth feel "rooted" in the customs of the community):

Y: __ N: __

b) Does the community support, through individuals, transitional challenges - adolescence to adulthood? (e.g. sense of belonging/connectedness):

Y: __ N: __

c) Self identify promotion within cultural context (degree of integration/traditional customs and practices exercised); is a cultural home provided?

Please explain:

____

____

____

d) Capacity of community culture to ground adolescents undergoing self-identity/transitional issues; how is this addressed?

Please explain:

____

____

____

e) Degree of loss of sense of connectedness to the future (e.g. multiple placements of children/youth in care); how is this addressed?

Please explain:

____

____

____

f) Ability to find a personally persuasive means of warranting self-continuity in time (loss of sense of connectedness to their own future); how is this addressed? Please explain:

____

____

____

g) Describe how well the current social and mental health delivery system including CFS, is responding to the community problem situation:

____

____

____

COMMUNITY TREATMENT PLAN

a) What challenges need to be addressed?

Please explain:

____

____

____

b) What strengths does the community have, that can be built on, to address the current situation?

Please explain:

____

____

____

c) How can "cultural continuity" within the community be strengthened?

Please explain:

____

____

____

d) What is the "treatment plan" for the community?

Please explain:

____

____

____

____

____

e) What is the estimated duration - time line?

Please explain:

____

f) What resources are needed (based on effective use of existing resources such as BFI, BHC, NNADAP, CHR, NIHB Mental Health, Aboriginal Healing Foundation and other funding sources)? Provide cost breakdown and budget:

____

____

____

____

g) Describe how services will be integrated and co-ordinated to ensure there is a case management system in place:

____

____

____

____

h) Expected community outcomes by mileposts based on time line?

Please explain what outcomes, when, how to be measured:

____

____

____

____

i) Evaluative process to be utilized?

Please explain:

____

____

____

____

____

j) Reporting/accountability arrangement suggested?

Please explain:

____

____

Concluding Remarks

Clearly defined community assessment findings may enable the First Nations and Inuit Health Branch (FNIHB) of Health Canada to address community problem situations at an early stage. In order to assist identified communities the FNIHB will be required to examine implementation of its community and NIHB mental health policies and dedicate additional resources in order to implement planned response strategies before communities go into a state of high crisis.

This assessment guideline may assist the FNIHB in "pilot testing" the National Interim Program Directive for the provision of Mental Health Services. It can identify a community "at risk" and facilitate the development of assessments and treatment plans for such communities, building upon results achieved.

Appendix G

Community Development

At first glance the concept of community development, mentioned in Part 3 of the preceding report, seems self-explanatory. However, in defining the steps in a process intended to bring about community development, "community" and "development" can mean many different things. Their meaning can vary based on one's political and cultural orientations as well as desired objectives. In an attempt to classify a range of approaches to community development, Brian Stanfield of the Canadian Institute of Cultural Affairs identified fifteen approaches, within the following four groupings[1]:

- Development dominated by expert and professional elites (i.e. social planning);
- Geographically based, citizen-directed approaches (whole system community development, community Economic Development);
- Community Based Programming (i.e. credit unions); and
- Ideologically Derived Programming (i.e. Sal Alinsky approach to organizing).

CITIZEN ENGAGEMENT

Establishing a means for citizens to voice their policy concerns initiates the process of citizen engagement.[2] Five general principles have been identified regarding citizen engagement: information (government must provide timely and accessible information); representation (accommodations have to be made for all); accountability (full explanations and avenues to share perspectives about decisions made and outcomes of these); community (members cooperate, trust one another, bond over common issue, get educated and empowered in the process); and relationship (an open process helps community members to feel like equals to the government and to perceive a genuine interest in their welfare)[3].

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[1] Stanfield, ____.

[2] Miriam Wyaman, David Shulman & Laurie Ham. Learning to Engage: Experiences with Civic Engagement in Canada www.cprn.com (1999): 1-30.

SOCIAL COHESION

In a cohesive society, people buy into collective social processes such as paying school taxes even though they do not have children in school. They extend trust to others, and have faith in institutions to protect them from risk and resolve conflicts fairly and openly. Members of a society are willing to cooperate and undertake voluntary collective action when they share values such as freedom, equality, democracy, respect for human rights, tolerance, inclusion, collective responsibility, and rule of law. Social cohesion provides the conditions under which these values can arise and flourish in a society.

Authoritarian regimes and beleaguered communities can mimic the signs of social cohesion but not reproduce it. They create orderliness, shared values, communities of interpretation, and a sometimes dramatic ability to undertake collective action, at the cost of being coercive, exclusionary, and rarely sustainable[4].

INTEGRATION

The successful integration of community services requires extensive planning, effective communication channels between partner programs and/or organizations and trained personnel before project implementation. Leadership and well-defined roles and responsibilities are critical to the process.

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[3] Edward C. Lesage Jr., Frances Abele, Walter Kubiski and John C. Robinson.
[4] Source: Holding the Centre: What We Know About Social Cohesion, by Strategic Research & Analysis and the Social Cohesion Network, January 2001.

SOCIAL COHESION

Social cohesion refers to the willingness of people to cooperate and act together. Cooperation and collective action take place at all levels of life—personal, community, club or social group, economy, and nation. Social cohesion and fundamental liberal social values exist in a reciprocal and mutually reinforcing relationship.

Draft Tools for Community Development Facilitators

Tables One and Two present examples of tools which facilitators could use to help support the communities in the development of their programs. The template presented in Table One acknowledges that programs could be designed to deal with each factor at various levels of prevention (primary, secondary, tertiary) using various levels of intervention (community, institutional, family and individual). This tool could help communities think through the design of their program in a thorough manner while leaving them free to address their issues in their own way. For example, one community may be in crisis after experiencing a number of recent suicides. Given this situation they may need to develop and implement a number of tertiary (postvention) programs and secondary prevention programs to stabilize the situation. Table Two offers a starting point for communities to map out their existing programmatic resources.

The tools combine the four categories of issues involved in youth suicide identified by the Royal Commission on Aboriginal Peoples[1] (psycho-biological factors, life history or situational factors, socio-economic factors, cultural stress), the three levels of prevention (primary, secondary and tertiary), the level of the intervention (community, institution, family or individual) as well as the various age ranges in order to try and map the components of a comprehensive system.

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[1] Royal Commission on Aboriginal Peoples. Choosing Life: Special Report on Suicide Among Aboriginal People (Canada Communication Group Publishing, 1995) p.20

Table One: Guide for Development of Comprehensive Suicide Prevention Program

Level of Intervention	Level of Prevention	Factors Contributing to Suicide	Range of Programs (examples of existing programs)	Age Range
Community	Primary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Secondary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Tertiary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
Institutional	Primary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Secondary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Tertiary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
Family	Primary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Secondary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Tertiary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
Individual	Primary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Secondary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		
	Tertiary	Psycho-biological		
		Life History/Situational		
		Socio-Economic		
		Cultural Stress		

Psycho-biological factors (depression, anxiety disorders, schizophrenia,....)

Life history or situational factors (chronic family instability, family history of mental health problems, experience of physical or sexual abuse, substance abuse, a history of interpersonal conflict, recent extreme interpersonal conflict or the loss of a major relationship, prolonged or unresolved grief, imprisonment, substance abuse, current access to lethal means, absence of religious and spiritual commitment...)

Socio-economic factors (unemployment, individual and family poverty, relative deprivation or low class status, low standards of community health, lack of stability and prosperity)

Cultural stress (i.e. loss of confidence by individuals or groups in the ways of understanding life and living (norms, values and beliefs) that were taught to them within their original cultures and the personal or collective distress that may result - loss of land, loss of control over conditions and restricted economic opportunity, suppression of belief systems and spirituality, weakening of social institutions, displacement of political institutions, pervasive breakdown of cultural rules and values and diminished self-esteem, discrimination and institutional racism and their internalized effects, voluntary or involuntary adoption of elements of an external culture and loss of identity)

Table Two: Summary of Federal Programs Available to First Nations and Inuit Communities

Age Range	Factors Contributing to Suicide	Programs which Address Factors contributing to suicide
0-6	Psycho-Biological Factors	
	Life History or Situational Factors	Brighter Futures (Mental Health) Head Start Canada Prenatal Nutrition Program
	Socio-Economic Factors	Head Start
	Cultural Stress	Head Start
7-12	Psycho-Biological Factors	
	Life History or Situational Factors	
	Socio-Economic Factors	
	Cultural Stress	Junior Canadian Rangers Program (HRDC) (Age 12-18)
13-18	Psycho-Biological Factors	
	Life History or Situational Factors	
	Socio-Economic Factors	First Nations SchoolNet First Nations and Inuit Career Summer Placement Program (DIAND) (Age 15-30) First Nations and Inuit Youth Business Program (DIAND) (Age 15-30) First Nations and Inuit Youth Experience Program (DIAND) (Age 16-30)
	Cultural Stress	Junior Canadian Rangers Program (HRDC) (Age 12-18)
19-25	Psycho-Biological Factors	
	Life History or Situational Factors	
	Socio-Economic Factors	Aboriginal Business Canada-Youth Entrepreneurship Program (Industry Canada) First Nations and Inuit Career Summer Placement Program (DIAND) (Age 15-30) First Nations and Inuit Youth Business Program (DIAND) (Age 15-30) First Nations and Inuit Youth Experience Program (DIAND) (Age 16-30)
	Cultural Stress	
Community	Life History or Situational Factors	Family Violence Program (DIAND) First Native Alcohol and Drug Abuse Program (FNIHB)
	Socio-Economic Factors	Aboriginal Business Canada (Industry Canada) Federal Procurement Strategy for Aboriginal Business (Indian and Northern Affairs Canada) designed to help Aboriginal Firms do more contracting with federal departments, and agencies[2]
	Cultural Stress	First Nations SchoolNet

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[2] December 11/99,
www.cbsc.org/nb/display.cfm?BisNumber=2675&Coll=Federal_Bis

Appendix H

Recommended Administrative Infrastructure to Support Demonstration Projects

The following table, referenced in Part 3 of the preceding report, outlines the roles, responsibilities and accountabilities of the respective components of what could make up the administrative infrastructure for the demonstration projects. Figure 1 diagrams the same structure.

Table Three: Summary of Federal Programs Available to First Nations and Inuit Communities

Component	Role	Responsibilities	Accountability Mechanism
FINHB	Establish Program Framework Establish Evaluation Framework Provide Funding	Ensure comprehensive approach is achieved	Framework and contribution agreement signed between FNIHB and Community
National Program Coordinating Committee (Made up of representatives from FNIHB, Provincial Governments, First Nations, other relevant federal departments, experts in relevant fields)	Advocate and support community demonstration projects	To monitor all community program plans Receive all evaluation data Generate and disseminate information and knowledge generated by evaluation including best practices on suicide prevention Coordinate funders for program ideas which emerge from community development processes	Terms of Reference
Regional Resource Commitee (Made up of representatives from FNIHB regional office, Provincial Government, First Nations, other relevant federal departments at regional level)	To liaise with local coordinating committees and advocate for resource needs	Support local coordinating committees	Terms of Reference

Component	Role	Responsibilities	Accountability Mechanism
Local Coordinating Committees (made up of local elders, youth, health care workers, educators, social service workers, provincial government representatives and First Nation and Inuit Health Branch representatives)	Establish linkages between key sectors, resources and individuals in the community	Oversee community engagement process	Framework and agreement signed between FNIHB and Community
Local Coordinator /Facilitator	Support Coordinating Committee in carrying out its responsibilities	Facilitate community engagement process	Employment Contract, or Framework and agreement signed between FNIHB and Community
Service Delivery Agencies	Provide necessary services and supports	Collect evaluation data and send to National Coordinating Committee implement data collection tools for evaluation	Agreements and protocols

The attached diagram (Figure 1) shows the recommended administrative infrastructure at the national, regional and local levels with linkages to federal and provincial governments and resource people from various fields.

Suggested Administrative Infrastructure

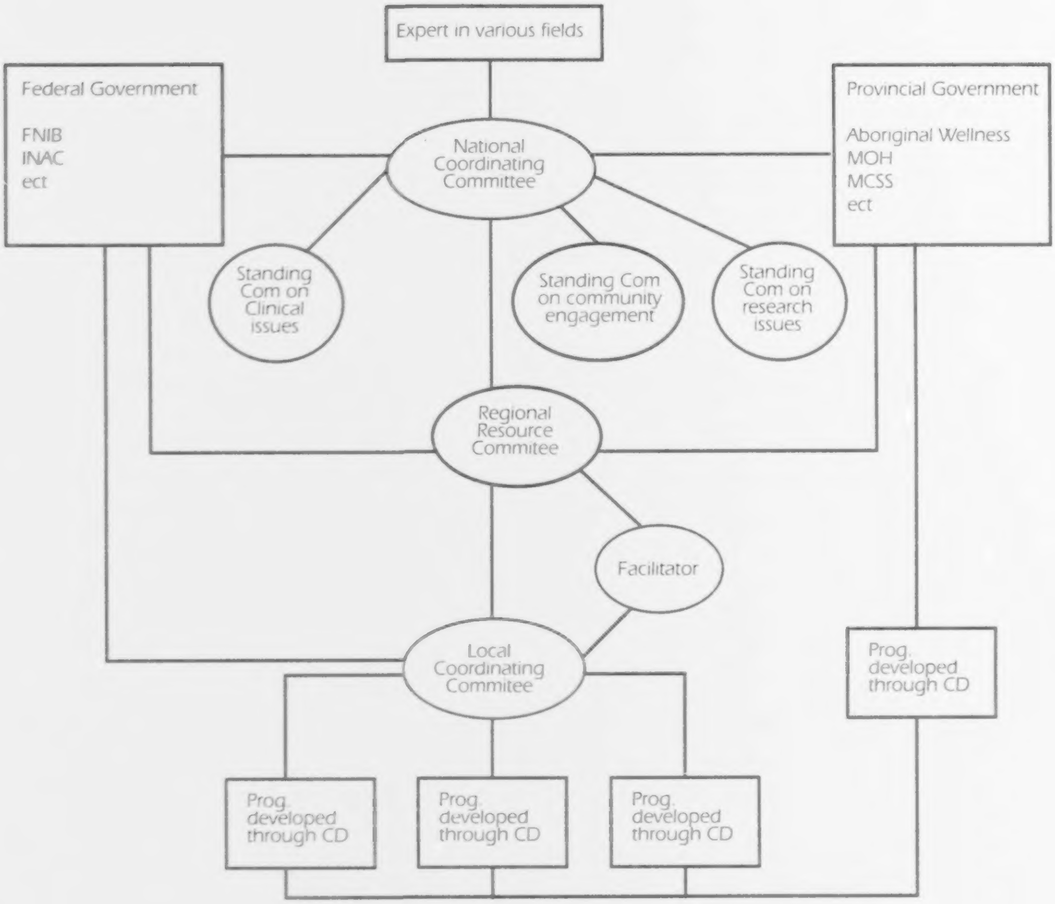
Expert in various fields
Federal Government
FNIB
INAC
ect
Provincial Government
Aboriginal Wellness
MOH
MCSS
ect
National Coordinating Committee
Standing Com on Clinical issues
Standing Com on community engagement
Standing Com on research issues
Regional Resource Commitee
Facilitator
Local Coordinating Commitee
Prog. developed through CD
Prog. developed through CD
Prog. developed through CD
Prog. developed through CD

Figure 1

Appendix I

Glossary of Terms

AFN: Assembly of First Nations, a national organization representing approximately 700,000 First Nations citizens in Canada. It advocates and supports the diverse goals, rights, aspirations, traditional and spiritual values of First Nations citizens for all generations.

BFI: Brighter Futures Initiative of Health Canada, one of four federal funding streams for mental health-related services. BFI supports community-based activities within a community development framework that fosters the well-being of First Nations children, their families and communities.

BHC: Building Healthy Communities, another Health Canada initiative which supports the development of specialized, community-based mental health crisis intervention training and services and solvent abuse programming.

CDC: The U.S. Centers for Disease Control and Prevention, part of the U.S. Department of Health and Human Services.

CICH: Canadian Institute of Child Health, a national organization dedicated to improving the health status of Canadian children and youth.

First Nation: Entities formerly referred to and legally recognized in the federal Indian Act as "bands". Section 35 of the Canadian Constitution (1982) protects the existing Aboriginal and treaty rights of First Nations and two other distinct groups of Aboriginal peoples, Inuit and Metis.

FNIHB: First Nations and Inuit Health Branch of Health Canada (formerly Medical Services Branch), which works with First Nations and Inuit people to improve and maintain the health of First Nations and Inuit peoples.

IAPH: Institute for Aboriginal Peoples' Health, a branch of the Canadian Institutes of Health Research (CIHR), a federal agency responsible for funding health research in Canada.

NAHO: National Aboriginal Health Organization, a national Aboriginal designed and controlled organization dedicated to improving the physical, social, mental, emotional, and spiritual health of Aboriginal Peoples.

NIHB: Non-Insured Health Benefits, a third mental-health related program provided to First Nations through Health Canada. In addition to pharmaceuticals, medical supplies and equipment, dental and vision care and medical transportation, NIHB funding covers some professional mental health treatment and crisis intervention counselling.

NNADAP: The National Native Alcohol and Drug Abuse Program, a fourth mental-health related program of Health Canada which supports community-based workers and First Nations-managed culturally appropriate treatment for alcohol and other substance abuse.

RCAP: The Royal Commission on Aboriginal Peoples, which conducted an extensive commission of inquiry on Aboriginal issues across Canada and produced several volumes of research, culminating in a final, five-volume report in 1996.

SPAG: The Suicide Prevention Advisory Group, a panel of eight Aboriginal and non-Aboriginal researchers and health practitioners appointed in 2001 by the National Chief of the Assembly of First Nations and the Hon. Allan Rock, former Minister of Health, to make recommendations regarding the prevention of suicide among First Nations youth.

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